Northern Arizona Regional Behavioral Health Authority

1300 South Yale Street Flagstaff, Arizona 86001

Maurice W. Miller, A.C.S.W. Chief Executive Officer

February 9, 2005

Jon Medwin, Procurement Administrator
Arizona Department of Health Services
Procurement Office
1740 West Adams Street, Room 303
Phoenix, AZ 85007

RE: Soliciation No. HP532003 – Request for Proposals (RFP)
Behavioral Health Services Administration – Greater Arizona
Best and Final Offer

Dear Mr. Medwin:

Attached you will find the NARBHA response to the items listed in the Best and Final Offer request letter dated January 28, 2005.

If you have any questions regarding our response, please contact me at (928) 774-7128.

Sincerely,

Maurice W. Miller, ACSW
Chief Executive Officer

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Volume 1, Item d – Limit 2 pages.

- **Provide three references as required by the Offeror Business Information form.**

- **Identify the Board Members' business and professional affiliations.**

- **Describe what measures Offeror will implement to ensure that any conflicts of interest for Board Members who are also providers are mitigated. Include that Board Members who are also providers must sign a conflict of interest statement that requires them to recuse themselves from voting on issues that impact their provider agency as well as other topics pertaining to providers (i.e., funding allocations).**

- **Describe how the Offeror will hold providers who sit on the Board accountable.**

- 1. Community Counseling Centers, Inc.
  105 North Fifth Avenue
  Holbrook, AZ 86025
  (928) 524-6701
  Contact person: Dr. Robert Wilderman
  Services provided: Provider of mental health and substance abuse services to the general public.
  Contract Start/End Dates: 07/01/01 – 06/30/04
  Contract Value: $23,082,404

  2. Little Colorado Behavioral Health Centers, Inc.
  P.O. Box 579
  St. Johns, AZ 85936
  (928) 337-4301
  Contact person: Mr. Michael Downs
  Services provided: Provider of mental health and substance abuse services to the general public.
  Contract Start/End Dates: 07/01/01 – 06/30/04
  Contract Value: $6,182,739

  3. Mohave Mental Health Clinic, Inc.
  1743 Sycamore Avenue
  Kingman, AZ 86401
  (928) 757-8111
  Contact person: Mr. Bud Brown
  Services provided: Provider of mental health and substance abuse services to the general public.
  Contract Start/End Dates: 07/01/01 – 06/30/04
  Contract Value: $45,912,608

- **Clay Overson, President – Technician, Salt River Project,** Apache County Service Area, additional representative, St. Johns, AZ
  Scott Garms – City Manager – Town of Springerville, Apache County Service Area, provider representative, Eagar, AZ
  Jana Mangum, Vice President and Nominating and Personnel Committee Chairperson – Apache County Clerk of the Court, Chief Deputy, Apache County Service Area, non-provider representative, St. Johns, AZ
  Jay Fleishman, MD – Pathologist, Eastern Yavapai County Service Area, provider representative, Cottonwood, AZ
  Vacant - Eastern Yavapai County, non-provider representative
  Leon Nuvayestewa – Director, Hopi Health Department, Hopi Tribal Service Area, tribal representative, Kykotsmovi, AZ
  Mark Sippel, Treasurer and Finance Committee Chairperson – Attorney (Private Practice), Mohave County Service Area, non-provider representative, Kingman, AZ
  Vacant - Mohave County Service Area, provider representative
  Bill Jeffers – Rancher, Navajo County Service Area, provider representative, Holbrook, AZ

Frank Lucero – Navajo County Adult Probation Officer, Navajo County Service Area, non-provider representative, Holbrook, AZ
William Gillam – Consumer, NAZCARE Representative, Lakeside, AZ
Pete Dow – Retired, Northern Coconino County Service Area, provider representative, Page, AZ
Vacant - Northern Coconino County Service Area, non-provider representative
Becky Senseman-Lewis – Homemaker (Attorney by profession), Southern Coconino County Service Area, provider representative, Flagstaff, AZ
Lina H. Wallen – Flagstaff Housing Authority Counselor, Southern Coconino County Service Area, non-provider representative, Flagstaff, AZ
Marriner Cardon – Attorney (retired), Western Yavapai County Service Area, provider representative, Prescott, AZ
Phil Clayton, Secretary, Planning and Program Committee Chairperson – Voc Rehab Counselor, Arizona Department of Economic Security, Western Yavapai County Service Area., non-provider representative, Prescott, AZ
Charlotte Quintero – Consumer, White Mountain Apache Tribal Service Area, tribal representative, Ft. Apache, AZ
Tonita Standing – Consumer, White Mountain Apache Tribal Service Area, non-tribal additional representative, Whiteriver, AZ

- 1. NARBHA's Bylaws currently state "No Member of the Board shall vote if he or she has a conflict of interest in the matter to be decided".
  2. NARBHA's conflict of interest policy currently states that Board Members "may not participate in the discussion or vote on any decision in which they have a conflict of interest or have declared a conflict of interest."
  3. Board of Directors members are required to submit a written disclosure/conflict of interest statement to the NARBHA CEO at the time of appointment and when their individual situation changes.
  4. The Conflict of Interest policy will be amended to require Board Members representing provider agencies to recuse themselves from voting on issues that impact their provider agency, i.e. funding allocations.
  5. NARBHA Board Members representing Service Area Agency (SAA) providers are community members, not "professional" or paid staff of provider agencies.
  6. The NARBHA Board is comprised of 18 members. Each SAA is allocated one seat and one non-provider representative is elected from each SAA area. The Hopi and Apache tribal governments are each allocated a seat on the Board. NAZCARE, the consumer operated program, is also allocated a seat on the Board. This structure ensures a balance of power and equal representation from all sub-geographic areas of the large rural area served.
  7. NARBHA Bylaws and policy outline a process prohibiting Board Members from participating in discussions or voting on matters in which they have a conflict of interest. The policy will be amended to require Board Members representing provider agencies to recuse themselves from voting on issues that impact their provider agency, i.e. funding allocations.
  8. The NARBHA Board delegates to the CEO and administration the ability to make decision regarding corrective actions, sanctions, or other actions that may be needed to correct substandard performance or improve quality. The NARBHA Board, also, is not involved in making provider network decisions, i.e. which providers receive a contract.
  9. NARBHA contracts with many non-SAA/TAA behavioral health services providers. The current number of non-SAA/TAA provider sites is approximately 75. This number does not include single case agreement providers.
  10. The bylaws provide that termination of Board Membership shall occur upon a member's failure to act in a manner consistent with the Bylaws and federal or state guidelines, regulations or laws. The removal is made by the majority vote of the Board of Directors.

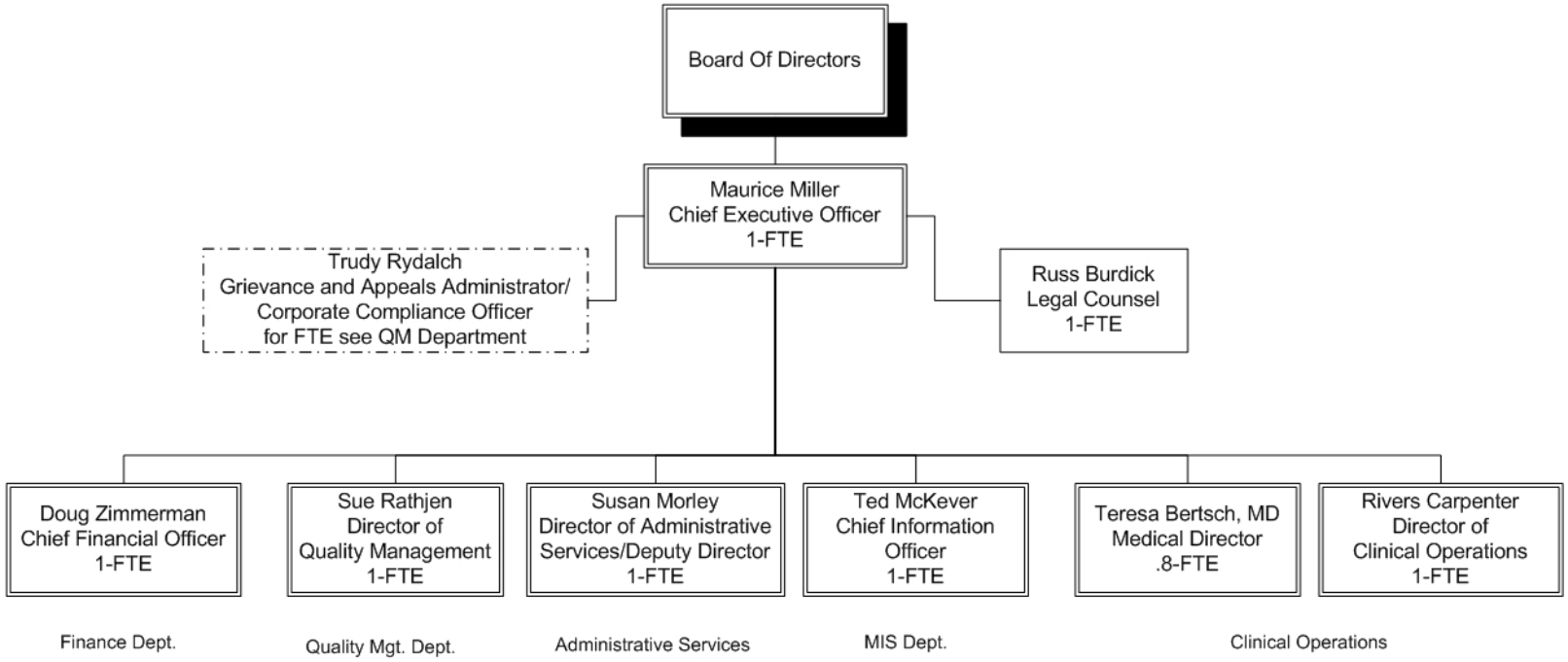
Volume 1, Item f

- **Resubmit the organizational charts that reflect what Offeror presented and described at the Site Visit.**

See attached NARBHA Organizational Chart

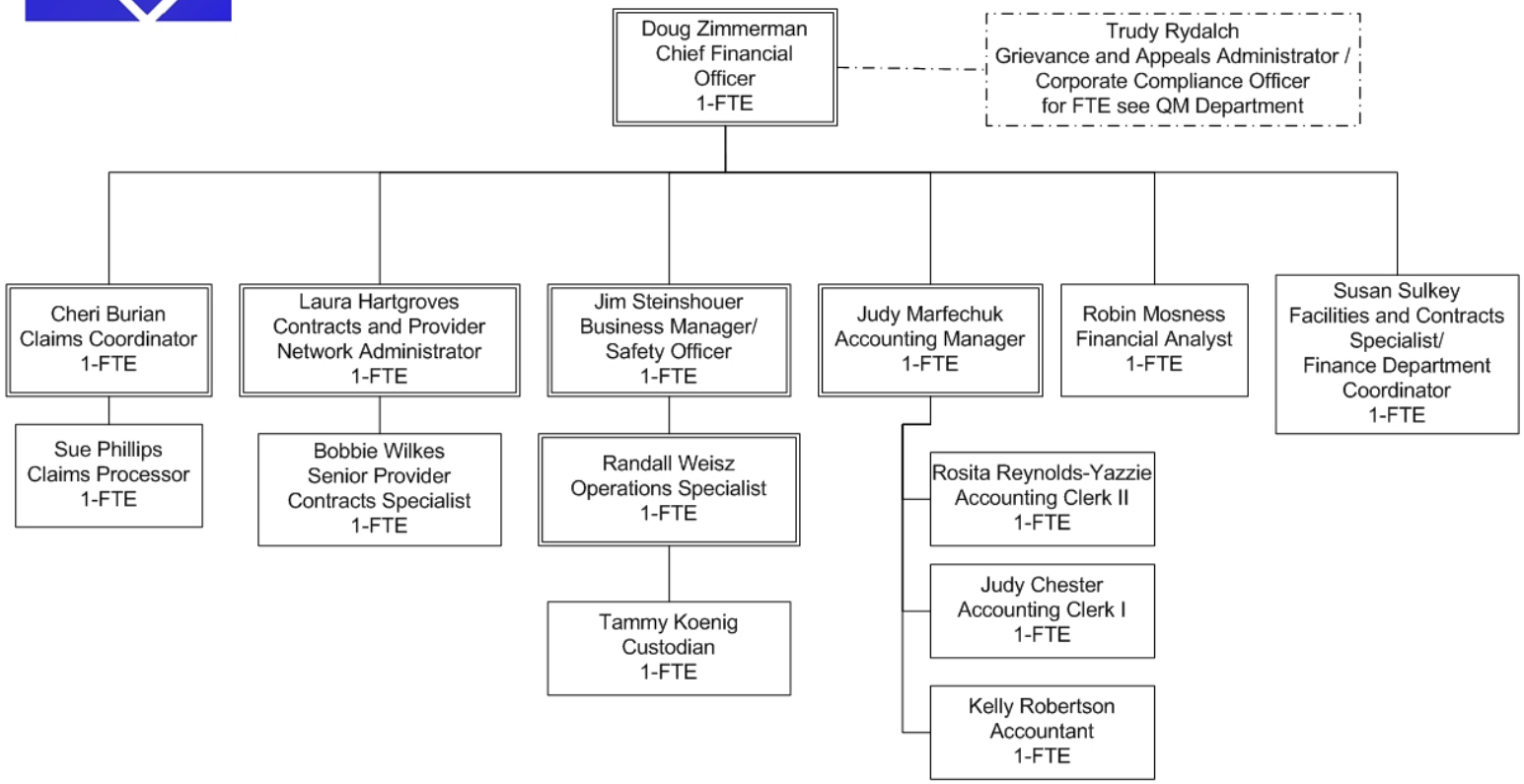
1

Northern Arizona Regional Behavioral Health Authority



1

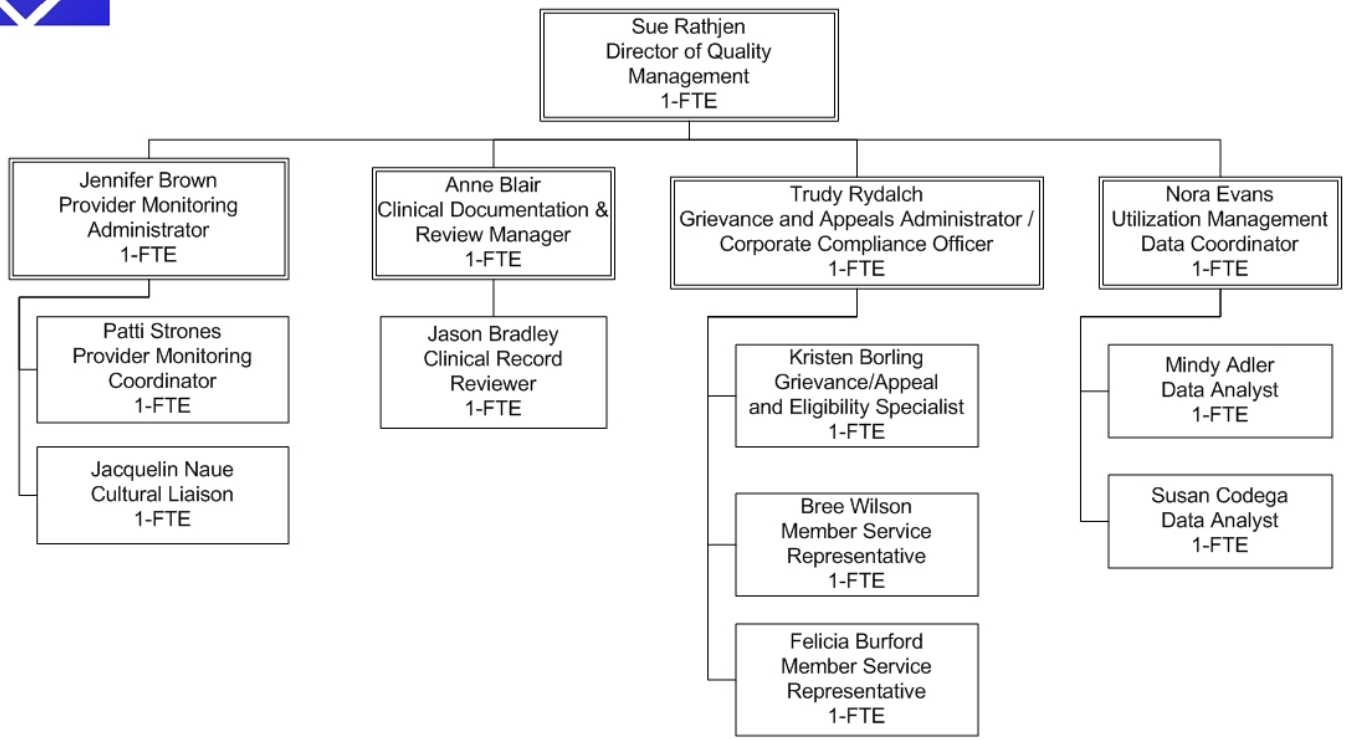
Finance Department



FINANCIAL ADMINISTRATION, FINANCIAL STATEMENTS AND REPORTS, OVERSEE INDEPENDENT AUDIT, COST FINDING AND RATE SETTING, FISCAL COMPLIANCE, FUND ALLOCATION, ACCOUNTING SYSTEMS, BUDGET PREPARATION AND ANALYSIS, PURCHASING, CLAIMS SYSTEM, CUSTOMER SERVICE, CLAIMS QUALITY ASSURANCE, NETWORK MANAGEMENT

1

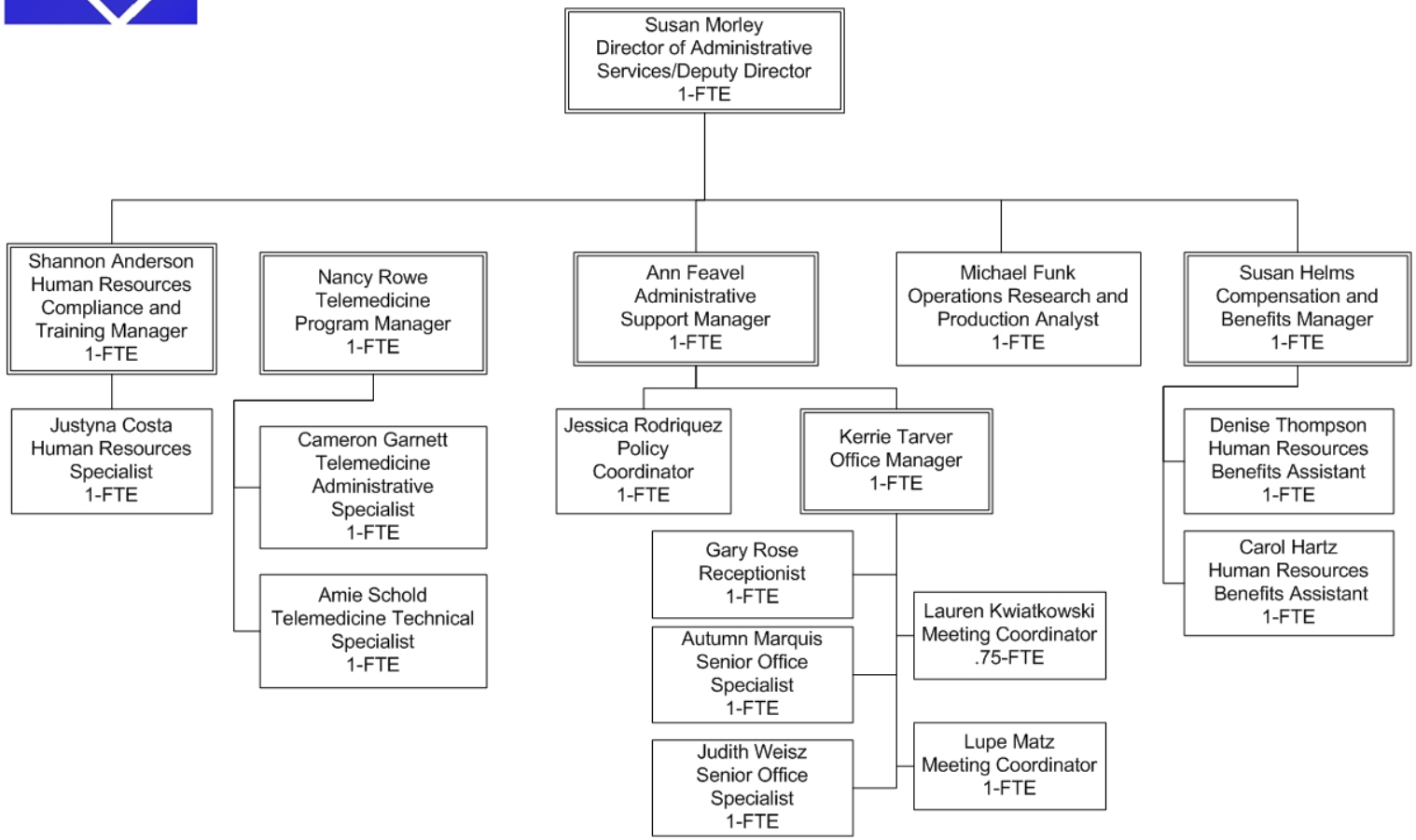
Quality Management Department



QUALITY MANAGEMENT SYSTEM, QUALITY MANAGEMENT INDICATORS AND PLAN, CRITICAL INCIDENT REPORTS, CLIENT GRIEVANCE AND APPEAL PROCESS, HUMAN RIGHTS AND CLIENT ADVOCACY, UTILIZATION MANAGEMENT, MEDICAL CARE EVALUATION STUDIES, CLIENT SATISFACTION. CLINICAL RECORD REVIEW, MEMBER SERVICES, CULTURAL COMPETENCY, CORPORATE COMPLIANCE, PROVIDER PERFORMANCE INDICATORS AND MONITORING.

1

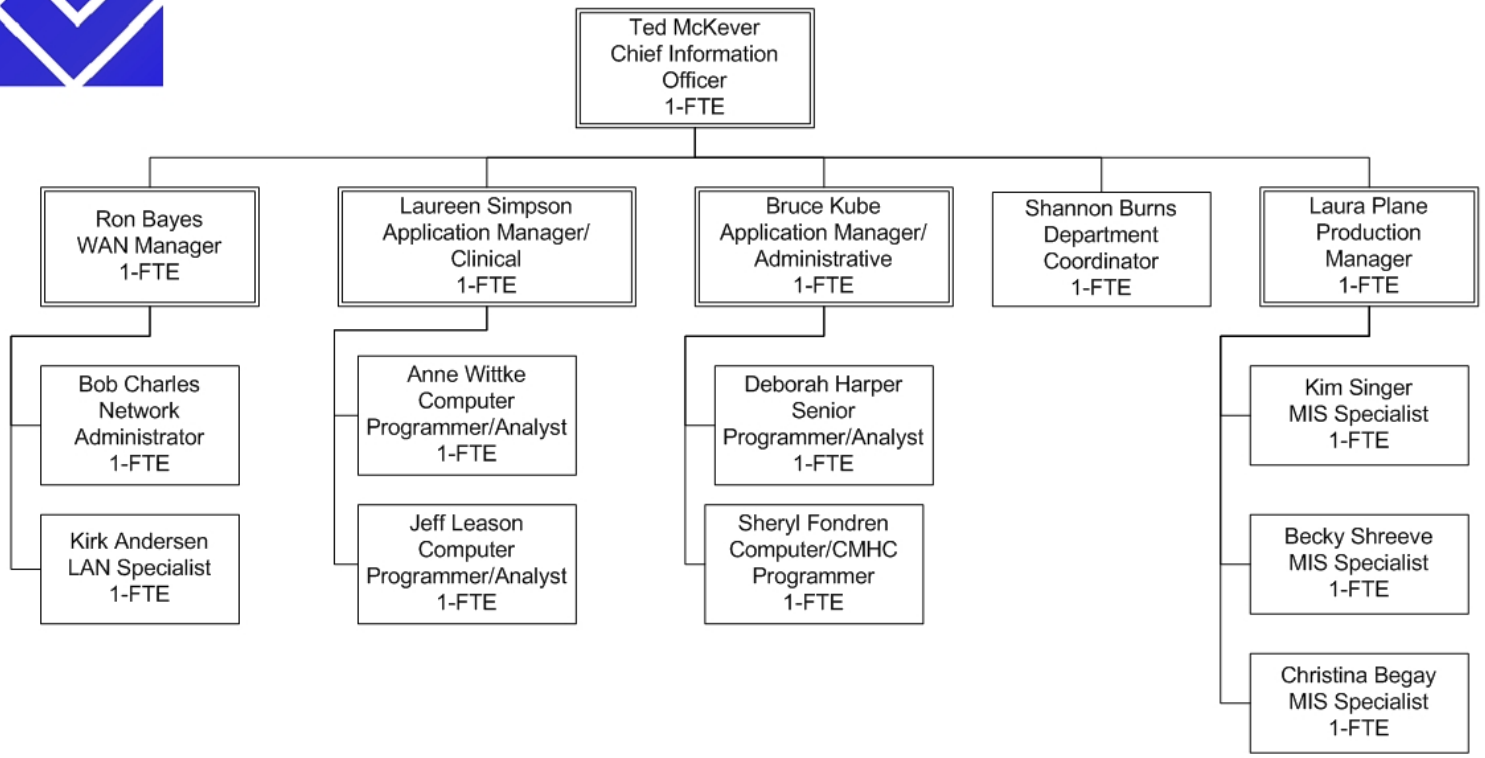
Administrative Services Department



RECRUITING/HIRING, TRAINING, PERSONNEL POLICIES, PERSONNEL AND BENEFITS ADMINISTRATION, PROFESSIONAL INSURANCE MANAGEMENT, CREDENTIALING/PRIVILEGING, PUBLIC RELATIONS AND MARKETING, OFFICE ADMINISTRATION, TELEMEDICINE, OPERATIONS RESEARCH/EVALUATION, POLICY COORDINATION.

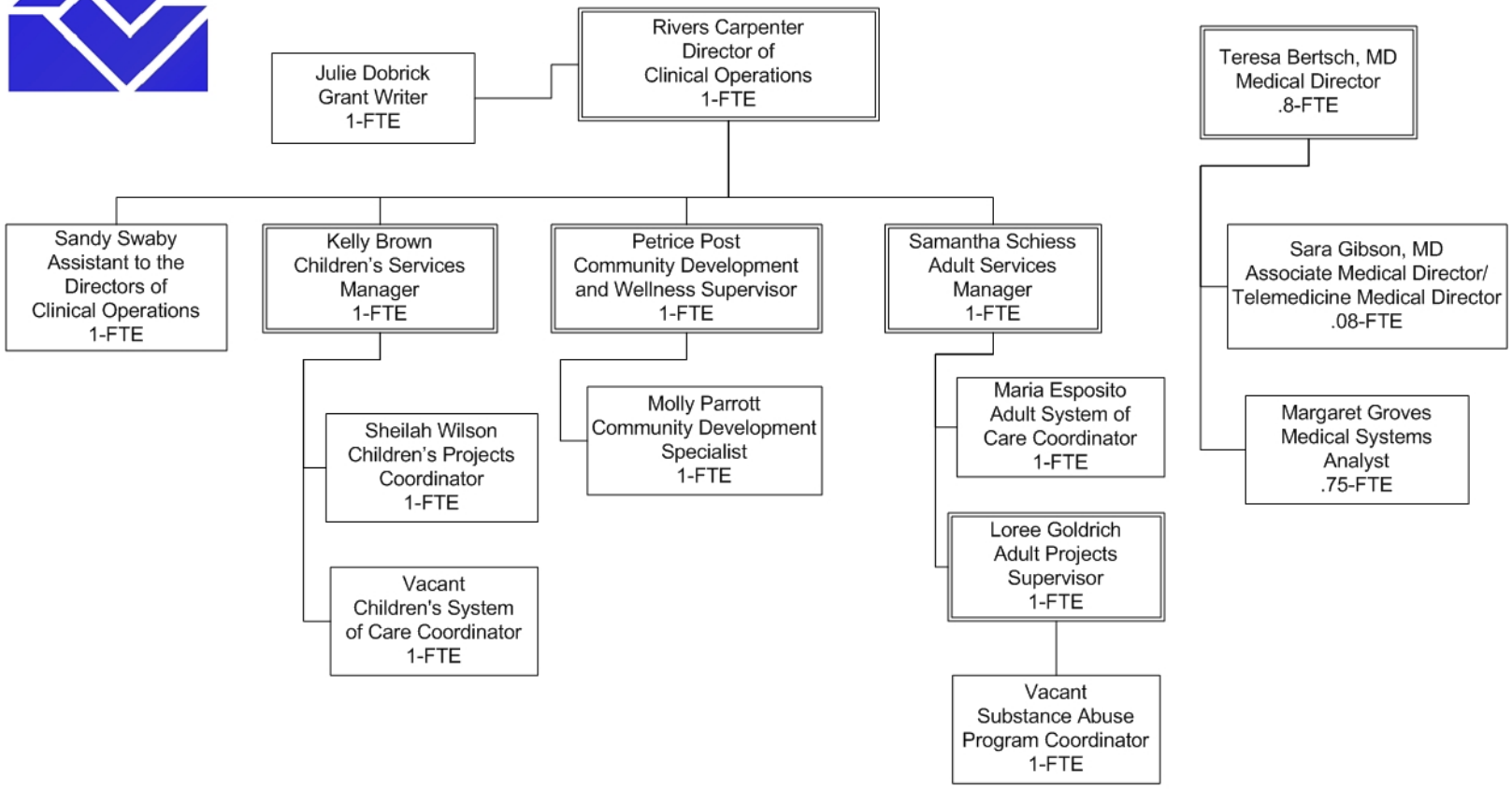
1

MIS Department



MIS SYSTEM ANALYSIS, DESIGN AND DEVELOPMENT, COMPUTER PROGRAMMING, SOFTWARE ANALYSIS, DEVELOPMENT AND MAINTENANCE, DATA REPORT DESIGN AND PREPARATION, LIAISON WITH STATE AND SUBCONTRACTOR AGENCIES ON MIS, DESIGN AND IMPLEMENTATION OF EVALUATION AND TRACKING SYSTEMS, HARDWARE SYSTEM DESIGN, PURCHASE, AND MAINTENANCE, WEB SITE IMPLEMENTATION, DESIGN AND MAINTENANCE.

Clinical Operations Department



CLINICAL PROGRAM PLANNING AND DEVELOPMENT IMPLEMENTATION AND MONITORING, POLICY AND STANDARDS DEVELOPMENT, CORRECTIONAL OFFICER/OFFENDER LIAISON PROGRAM, HOUSING, VOCATIONAL REHAB, RBHA AND PROVIDER MEDICAL DIRECTION, FORMULARY, FAMILY LEADERSHIP, COMMUNITY DEVELOPMENT, PREVENTION. COORDINATION OF CARE COMMUNICATION WITH AGENCY AND COMMUNITY STAKEHOLDERS, CHILDREN'S PROGRAMS.

Volume 1, Item h – Limit 1 page plus the job description.

- **Discuss how the Policy Liaison's experience and qualifications are sufficient to fulfill contract requirements pertaining to document development and what the Offeror resubmits under Volume 1, item k.**

- **Resubmit the Pharmacy Administrator job description so that it meets all requirements including licensure.**

- **Confirm that the Offeror's Grievance and Appeals Administrator will meet requirements by July 1, 2005.**

- **The working title of the Cultural Expert is "Native American Tribal Liaison" which may inadvertently exclude other cultures. Provide the new job title per the Site Visit discussion.**

- **Policy Liaison -** The NARBHA Policy Coordinator's job responsibility is to provide administrative oversight for policy preparation. This includes coordination with ADHS/DBHS, distribution to assigned NARBHA policy authors, clerical/administrative support, and policy distribution to ADHS/DBHS, provider agencies, NARBHA staff, and other stakeholders. In addition, the Policy Coordinator is responsible to ensure policies are posted and maintained on NARBHA's web page to ensure information is accessible by everyone.

  NARBHA's Policy Coordinator has sufficient qualifications and experience to provide this level of coordination and clerical/administrative support to policy authors. Prior to this position, this person assisted the previous Policy Coordinator with this function. The Policy Coordinator is supervised by NARBHA's Administrative Support Manager who previously served as Policy Coordinator. Both functions are supervised by NARBHA's Director of Administrative Services/Deputy Director which ensures there is management oversight of this function.

  NARBHA assigns policy development to authors with expertise in and responsibility for the policy. NARBHA's internal policy on the development, review, and approval of policies requires that policies are developed, updated, edited, reviewed, and approved by qualified, educated staff, (licensed, degreed as appropriate), with experience and/or direct responsibility regarding the policy they are authoring. Policy authors are assigned by the NARBHA Leadership Council based on their education and experience, and per their job responsibility within NARBHA. Through this process, NARBHA ensures that policies and procedures are continually updated to adequately and consistently reflect the vision, strategic goals, and mission of ADHS/DBHS and NARBHA for the delivery of behavioral health services in GSA 1.

- **Pharmacy Administrator** - The Pharmacy Administrator's job description (see attached) has been updated to correctly reflect and meet all licensure requirements.

- **Grievance and Appeals Administrator -** NARBHA hereby confirms and is committed to ensure the Grievance and Appeals Administrator will meet the requirements as stated in the RFP by July 1, 2005. NARBHA is also committed, that if for some reason, the Grievance and Appeals Administrator does not obtain their Paralegal Certification by July 1, 2005, NARBHA will hire a Paralegal to fulfill the obligations as stated in the RFP.

- **Cultural Expert** – NARBHA has changed the job title of this position to "Cultural Liaison" (see organizational chart). NARBHA is committed to ensuring all cultures feel welcome and comfortable with the Northern Arizona region. This commitment is also reflected in the Cultural Liaison job description.

NARBHA JOB DESCRIPTION

POSITION TITLE: Pharmacy Administrator
SUPERVISOR: Medical Director
EXEMPT POSITION

GENERAL SCOPE OF WORK

Under direction of the Medical Director, provides consultation to NARBHA and provider network staff regarding processes that promote clinical best practices for cost-effective psychopharmacology and generally oversees NARBHA's medication services.

A. Job Responsibilities

1. Works closely with NARBHA Medical Director to establish processes ensuring smooth delivery of pharmacy services.
2. Assures that pharmacy benefits manager (PBM) has implemented all adjudication rules in accordance with NARBHA, ADHS/DBHS, and AHCCCS.
3. Reviews pharmacy utilization data and makes recommendations regarding improvement processes.
4. Makes formulary recommendations.
5. Keeps current with FDA advisories and warnings about formulary products.
6. Participates in Grievance and Appeals processes as necessary.
7. Assist in the implementation of evidence-based practices and assurance of clinical best practices.
8. Consults with NARBHA and Provider Network prescribers regarding pharmacy benefits and utilization management.

B. Educational/Experience Requirements

1. B.S. in Pharmacy; Licensed Pharmacist in Arizona.
2. Experience in analysis in pharmacy utilization data.
3. Experience with managed care principles.

Volume 1, Item i – Limit 1 page.

- **"Denial of Care" is listed as a separate function from the authorization function. Per the Site Visit discussion, remove this as a separate function from authorization. Confirm that all documents developed by the Offeror will not address this as a separate function.**

- **If there are additional management services that are subcontracted or delegated responsibility to providers that are not reflected in the proposal, provide this information.**

- **Confirm that the DHS Uniform Terms & Conditions will be used in all behavioral health provider and management services subcontracts.**

- "Denial of Care" has been removed as a separate delegated function from authorization, and is included as a component within the process of authorization and securing services as described in the ADHS/DBHS/NARBHA Provider Manual 3.14. Documents developed by NARBHA, including, but not limited to policies, subcontracts, and planning documents, will not address denial of care as a separate delegated function from authorization.

- Community Partnership of Southern Arizona (CPSA) is currently being sought as the Pharmacy Benefit Manager (PBM), a contracted management service, for pharmacy products and services for NARBHA Members. The target date for implementation is April 1, 2005. NARBHA is currently contracting with CareMark, a privately owned PBM, whose contract will terminate on April 1, 2005. If for some reason the contract with CPSA is not implemented, NARBHA will continue with CareMark.

- NARBHA hereby confirms that as of June 30, 2005 the DHS Uniform Terms and Conditions contained in the RFP proposal will be used in all of NARBHA's subcontracts for behavioral health services and in all NARBHA's subcontracts for management/administrative services. NARBHA has already drafted the necessary language changes to its subcontracts and will provide DBHS with this these draft changes, if desired by DBHS, to demonstrate NARBHA's commitment to fulfilling this requirement.

Volume 1, Item j – Limit 1 page.

- **For both customer service and crisis response, indicate what organization(s) will answer the calls and what the qualifications are of each of the individuals answering the calls during both regular business hours and non-business hours. Be sure to address this from a 24/7 perspective (Reference: RFP Scope of Work G.2 and G.5). If the Offeror subcontracts for or delegates the customer service function, specify how the Offeror will convey expectations that the subcontracted or delegated organization will have expertise to provide information, process referrals, and perform any of the customer service functions listed in the RFP. Further, provide any additional information or detail that will assist DHS in understanding these functions.**

- **Identify the toll free numbers for customer service and crisis. Discuss where these numbers are publicized. (RFP, Pg 22, G.2. and G.5)**

- **Customer Service:**
  Regular Business Hours –

  NARBHA employs two FTE's, referred to as Member Service Representatives, to perform all required customer service activities. These individuals directly answer the 800 NARBHA Customer Service Line from 8am-5pm Monday-Friday. One of the Member Service Representatives has a bachelor's degree in Sociology and 3 years behavioral health experience. The other individual has an Associates degree in office administration and customer service with 2.5 years behavioral health experience. These individuals have been trained in policies and procedures related to NARBHA and the behavioral health system.

  Non-Business Hours –

  NARBHA subcontracts with ProtoCall Services, a 24-hour crisis assessment, intervention, and intake service, to perform the customer service function on its behalf from the hours of 5pm-8am Monday-Friday and 12am-12pm Saturday, Sundays, and Holidays using this Customer Service Line. The staff members at ProtoCall Services are minimally Masters level behavioral health clinicians. To ensure that ProtoCall Services staff have the expertise to perform the customer service functions outlined in the RFP, NARBHA will extensively train the staff at ProtoCall Services on the following items/processes: customer-oriented approach, NARBHA member handbook, responding to inquiries, providing access to care information, processing referrals, processing complaints, and patching customer service calls to the crisis line and/or 911 as necessary.

  Crisis Response:
  Regular Business and Non-Business Hours

  NARBHA will continue to subcontract with ProtoCall Services to provide crisis response services to NARBHA members 24 hours a day, 7 days a week. However, individuals throughout the NARBHA region will now be able to directly reach a crisis therapist at ProtoCall Services using a single toll-free number, without going through an answering service.

  The staff at ProtoCall Services is responsible for crisis phone triage, crisis phone counseling, and patching a caller to a local crisis provider if a mobile crisis or face-to-face evaluation is required. The staff members at ProtoCall Services are minimally Masters level behavioral health clinicians.

  ProtoCall Services has demonstrated the ability to provide quality crisis services to the NARBHA region.

- **Toll-Free Numbers:**
  NARBHA Customer Service Line: 1-800-640-2123. This number is published in the NARBHA Member Handbook and on the NARBHA Website.

  NARBHA 24 Hour Crisis Line: 1-877-756-4090. This number will be published in the Yellow Pages (under: Crisis Services) in each service/tribal area, in the next publication of the NARBHA Member Handbook, and on the NARBHA Website.

Volume 1, Item k – Limit 1 page.

- **Describe how documents containing relevant behavioral health system requirements will be developed to ensure consistency with and achievement of the vision outlined in the RFP and that clinical practice is conducted in accordance with the principles outlined in the RFP. Address who will have strategic versus administrative responsibility for document development.**

Strategic Responsibility

NARBHA's Leadership Council has assigned responsibility to senior management staff for the development of all documents, including policies/procedures and plans. These assignments are based on functional areas of responsibility. By having a key staff member assigned responsibility by functional areas, NARBHA is able to ensure consistency with, and adherence to, behavioral health system principles and vision, as these individuals are fully knowledgeable about the vision and specific requirements from ADHS/DBHS and AHCCCS. As members of senior management and part of NARBHA's Leadership Council, these individuals regularly participate in discussions regarding the behavioral health system and its vision and principles as outlined in the RFP, ADHS/DBHS policy, and other direction from DBHS.

The following staff members have been assigned strategic development of documents:

Functional Area	Staff Assignment
Clinical Operations (service delivery system development in accordance with the behavioral health system vision; prevention; clinical oversight of delivery system)	Medical Director; Director of Clinical Operations
Information Management	Chief Information Officer
Performance Improvement (including monitoring of provider network)	Provider Monitoring Administrator
Fiscal (including claims/billing)	Chief Financial Officer
Human Resources (including training and credentialing)	Director of Administrative Services/Deputy Director
Utilization Management	Director of Quality Management
Grievance/Appeal	Grievance and Appeals Administrator
Corporate Compliance	Corporate Compliance Officer
Environment of Care/Infection Control/Member Safety	Safety Officer
Member Rights	Director of Quality Management
Member Education/Communication	Grievance and Appeals Administrator
Network Development	Contracts and Provider Network Administrator

Administrative Responsibility

Administrative responsibility for coordinating document preparation, including ensuring that required documents are completed in a timely manner, submitted to DBHS, provider agencies, NARBHA staff, and other stakeholders, and/or posted to NARBHA's website, as appropriate, is coordinated by the NARBHA Policy Coordinator (policies only) and the Administrative Support Manager. Supervision and oversight of administrative responsibility for document preparation is provided by NARBHA's Director of Administrative Services/Deputy Director. Any questions regarding assignment of document development that fall outside the scope of functional area responsibilities are determined by NARBHA's Leadership Council.

Volume 2, Item b – Limit 2 pages.

- **Describe what the Offeror will do when a disparity in services is identified within the GSA.**

- **Describe what specific steps the Offeror will take to improve penetration for non-CMDP Children (Title XIX), non-SMI Adults (Title XIX) and SMI Adults.**

- **Confirm Offeror's understanding that the Offeror is responsible for all Title XIX/XXI eligibles in GSA 1, both on and off reservation. (Reference: Eligibility Groups, B. 1.a. 3)**

- NARBHA's commitment is to continue the development of a system of care in which equivalent services are provided across its network. When a disparity in services is identified, NARBHA staff will evaluate why the disparity has occurred, and will identify any potential barriers to the development of the service which may be present. NARBHA does not typically choose to utilize the concept of "pilot projects" in selected service areas when rolling out new initiatives (unless grants or other monies are earmarked for a specific geographic area). Rather the requirement is that all of its providers implement DBHS initiated projects such as Child and Family Teams, 24-Hour Response, Transition to Adulthood, Adult Teams, etc.

  NARBHA staff will continue to work in concert with stakeholders, consumers, and family members in order to implement new services in a manner which allows consistent services across its network. NARBHA has developed committees such as the Children's Barriers Resolution Committee to address implementation challenges. In addition, NARBHA meets regularly with the regional offices of the Department of Developmental Disabilities and the Department of Economic Security to address systems issues and to brainstorm effective methods for the implementation of region wide programs and initiatives. NARBHA continues to meet with the following committees and work groups to ensure that effective and consistent programming is planned, designed, implemented, monitored, and managed for effectiveness: Therapeutic Foster Care Advisory Teams, the Regional Children's Council of Northern Arizona, Rehabilitation Services Administration, Arizona Families First, local and regional housing coalitions, county criminal justice task forces, regional prevention providers, NARBHA's Family Leadership Committee, OCSHCN community groups, and the Cultural Awareness and Diversity Committee.

- Describe what specific steps the Offeror will take to improve penetration for non-CMDP Children, non-SMI Adults and SMI Adults.

  NARBHA will take the following steps to improve penetration as follows:

  I) Title XIX GMHSA
     i) Increase detox and substance abuse treatment services per plan as outlined in BFO response to Volume 3, Item i.
     ii) Increase jail diversion programs consistently throughout the area.
  II) Title XIX SMI
     i) Increase jail diversion programs consistently throughout the area.
  III) Title XIX Children
     i) Increase referrals from CPS, juvenile courts, and schools through stakeholder collaboration.
     ii) Increase in-home services for CPS referrals.
  IV) For all Title XIX categories - based on approval from the Navajo Nations
     i) Increase outreach to persons residing on the Navajo reservation by placing referral information and Member Handbooks at strategic location on the reservation, i.e, hospitals and Social Service agencies.

If NARHBA is selected as the contractor for GSA 1, NARBHA requests a meeting with ADHS to discuss penetration issues as NARBHA's review of data does not indicate consistent low penetration rates in comparison with other RBHAs if one adjusts for reservation eligibles and revenue available.

- NARBHA confirms its understanding that NARBHA will be responsible for all Title XIX/XXI eligibles in GSA 1, both on and off the reservation, except when enrolled with an ADHS tribal contractor, as indicated in B.1 a.3 – Eligibility Groups covered under this contract.

Volume 2, Item c – Limit 2 pages.

- **Resubmit Attachment C. Address minimum network requirements and indicate any changes from the original proposal for the following:**
  - **Behavioral health recipients to deliver peer support services**
  - **Family members to deliver peer support services**
  - **Mobile Crisis**
  - **Prescriber Capacity**
  - **Therapeutic Foster Care – Child**
  - **Therapeutic Foster Care – Adult**
  - **Sub-acute psychiatric detoxification – Child**
  - **RTC**
  - **Supported Housing**
  - **Clarify number of inpatient Children's Beds within the GSA and the number out of region**
  - **Clarify number of pharmacy sites within the GSA**

    Responses shall take into consideration increased penetration assumptions
- **Designate any additional changes made to the proposal beyond items listed above.**

Attachment C Minimum Network Requirements

For the purposes of the BFO, NARBHA is addressing the items on Attachment C that were questioned in the January 28, 2005 ADHS/DBHS letter

Provider Type/Service	Minimum Number	Units		List Service Location(s) by Town/City
Sub-acute facility *Provider types B5, B6*	2_A	Number of child beds	2_A	Kingman
	2_A	Number of adolescent beds	2_A	Kingman
Inpatient services *Provider types 02, 71*	11_B	Number of child beds	11_B	Phoenix
	9_B	Number of adolescent beds	9_B	Flagstaff
RTC *Provider types 78, B1, B2, B3*	75_C	Number of child beds	75_C	Phoenix and Wickenburg
	256_C	Number of adolescent beds	256_C	Flagstaff, Cottonwood, Phoenix
Therapeutic Foster Care Homes *Provider type A5*	10_D	Number of adult placements	10_D	Southern Arizona
	43_E	Number of child placements	38_E	Throughout GSA
Housing	130 units 11 halfway houses 357 $beds_F$	Number of persons with a serious mental illness who will be assisted in locating or maintaining housing	121 units 11 halfway houses 339 $beds_F$	Throughout GSA
Pharmacy locations *Provider type 03*	50 in GSA 653 Statewide, not in GSA_G	Number of locations	50 in GSA 653 Statewide, not in GSA	Throughout state
Behavioral health recipients to deliver peer support services	19 FTEs and 10 part-time $volunteers_H$	Full time equivalents working in community service agencies or outpatient agencies	7 FTE_H	Flagstaff, Cottonwood, Prescott, Show Low, Kingman
Family members to deliver peer support services	5 FTE 6 part-time $volunteers_I$	Full time equivalents working in community service agencies or outpatient agencies	1 FTE 3 $volunteers_I$	Flagstaff, Cottonwood, Prescott, Show Low, Kingman

Provider Type/Service	Minimum Number	Units	List Service Location(s) by Town/City
Mobile crisis	10	Full time equivalents during business hours 10_J	Not applicable
	18_J	Full time equivalents after business hours 18_J	Not applicable

Staffing Type	Minimum Number	Units
Psychiatrists, Nurse Practitioners, or Physician Assistants	950_K	Number of hours per week dedicated to medication assessment and prescribing 832_K

Footnotes

A. The Level 1 Sub-acute facility (which is capable of providing detox services) in Kingman has two beds that are available for either children or adolescents. NARBHA's "minimum units" of sub-acutes for children is only two because, instead of using sub-acute services for children and adolescents, NARBHA typically utilizes specialized hospitals and RTCs for children and adolescents who need inpatient services.

B. NARBHA has a Fee-For-Service (FFS) contract with Flagstaff Medical Center for nine Psychiatric Acute Hospital and detox beds for adolescents and a FFS contract with Az. Childrens Hospital in Phoenix for 11 beds for psychiatric acute service for children. In addition, if the needs of NARBHA members require additional inpatient beds, NARBHA has single case agreements (for low-volume providers) with Sonora Behavioral Health Hospital, which has 4 children and 18 adolescent beds, Palo Verde Hospital, and St. Lukes Hospital which provide hospital services to both children and adolescents.

C. NARBHA has FFS contracts with providers of RTC beds for children that include: Childhelp USA (20 beds), Arizona Baptist Children (36 beds), and Devereux (19 beds). For Adolescents, NARBHA has 26 beds within its GSA (10 at The Guidance Center and 16 at The Mingus Center in Cottonwood). The opening of the Mingus Center in September 2004 was the successful completion of a NARBHA Provider Network expansion priority in NARBHA's 2004 ADHS/DBHS approved Network Sufficiency Plan. NARBHA also has FFS contracts for additional adolescent RTC beds at Parc Place (87 beds), YDI (84 beds), and Prehab (40 beds). In addition to these 256 adolescent RTC beds, NARBHA has single case agreements for adolescent RTC beds with Mingus Mountain Ranch (41 beds) and The New Foundation (41 beds).

D. NARBHA has a FFS contract with Devereux for access to Devereux's approximately 10 Adult Therapeutic Foster Care Beds. Based upon a 2004 NARBHA survey of consumers, 81% (n=48) of respondents indicated that adult therapeutic foster care was not a housing option that would meet their needs or be a desirable option. During 2004 one NARBHA member accessed Devereux's adult therapeutic housing. Based upon consumer input, NARBHA has focused Provider Network expansion in supported housing and providing case management to members living in private housing. Please see the response under item 2d "assumptions in developing Attachment C"

E. For child therapeutic foster care, by 7/1/05 NARBHA will increase child therapeutic foster care beds by adding five additional beds. NARBHA also intends to do the following: by 12/31/05, expand its beds by seven to a total of 50 (2 in Mohave County, 3 in Navajo County, and 2 in the region); by 07/01/06 NARBHA intends to expand its beds to 60 (an additional 4 in Mohave County, 2 in Navajo County, and 4 in the region); by 12/31/06 NARBHA intends to expand its beds to 65 region-wide. This will represent a 71% increase over current capacity.

F. NARBHA has greatly expanded and continues to expand supported housing in its GSA as part of its annual Network Sufficiency Plan that is approved and monitored by DBHS. Please see the response under item 2d for a description of recent expansion of supported housing.

G. NARBHA believes that this number of pharmacies exceeds the minimum number necessary to meet member's needs. However, because this is the number that NARBHA currently has within its system, this number was reported.

H Please see the response under item 2d "assumptions in developing Attachment C".

I Please see the response under item 2d "assumptions in developing Attachment C".

J. Please see the response under item 2d "assumptions in developing Attachment C".

K. Please see the response under item 2d "assumptions in developing Attachment C".

Volume 2, Item d – Limit 2 pages.

- **Specify assumptions used by the Offeror in identifying the minimum number of providers or services for all items identified above in Volume 2, item c – Minimum Network Requirements.**

NARBHA made the following assumptions in identifying the minimum number of providers or services for all items identified in the Best and Final Offer questions on Attachment C.

General Assumptions that apply to all items in Attachment C:

- Every year NARBHA makes significant expansions to its provider network to meet member needs.
- NARBHA's Provider Network expansion activities are done in cooperation with ADHS/DBHS. ADHS/DBHS approves and oversees NARBHA's Provider Network expansion projects and priorities.
- In the past several years NARBHA's provider network has greatly expanded in the following areas: Supported Housing, Therapeutic Foster Care Homes, Level 2 Residential Services for adults and adolescents, and consumer-operated drop-in centers that provide peer support.
- NARBHA continues to successfully shape and expand its Provider Network, with the oversight and approval of ADHS/DBHS. In 2004, NARBHA's Network Sufficiency Plan includes 20 separate priorities or expansion projects (many of which have already been successfully completed) which include Supported Housing; Residential and Inpatient Services; expansion of drop-in centers for peer support; expansion of services for members with both behavioral health needs and developmental disabilities; expansion of services to Comprehensive Medical and Dental Program (CMDP) children; including Multi-Systemic Therapy; expansion of detox (social model) services (see plan in Volume 3, Item j) and additional prescribers.

Specific Assumptions that apply to Attachment C

Behavioral Health Recipients to Deliver Peer Support

- The numbers in Attachment C are based upon the number of individuals who actually encounter and bill peer support; they do not include the informal peer support that is provided at NARBHA's subcontracted agencies. In addition, they do not include the significant amount of peer support that is provided via NAZCARE's Warmline because telephonic Peer Support is not an encounterable service.
- Within the past two years NARBHA has successfully established consumer-run services through NAZCARE. With NARBHA's extensive and on-going guidance, assistance, and support, NAZCARE has opened and is successfully operating consumer-run drop-in centers in Prescott, Cottonwood, Show Low, Flagstaff, and Kingman. As a result of NARBHA's recent Provider Network expansion projects, these peer support services are available throughout NARBHA's geographic region.
- The "minimum number" of units for "Behavioral Health Recipients to Deliver Peer Support" in Attachment C is based upon peer support being available to members in each sub-geographic area throughout NARBHA's expansive GSA.
- NARBHA will continue to demonstrate its commitment to Recovery by expanding Peer Support services and other covered services related to Recovery. Expansion will take the form of continued growth and support by NAZCARE, which will be adding and supporting additional paid and volunteer staff at the existing NAZCARE sites throughout NARBHA's region, and also by adding and supporting the addition of consumers to provide Peer Support and other Recovery services in NARBHA's SAAs.

Family Members to Deliver Peer Support

- The numbers in Attachment C are based upon the number of individuals who actually encounter and bill Peer Support; it does not include the informal Peer Support that is provided at NARBHA's subcontracted agencies.
- NARBHA assumes, at this time, that the "Minimum Number" of family members to deliver peer support is sufficient based upon the availability of that service throughout NARBHA's GSA.
- As NARBHA continues to expand its services delivered by family members, the NARBHA Family Leadership Committee will identify family members who are interested in providing family support. These family members will be provided with a choice of training opportunities provided by agencies such as NAMI (using the *Family to Family* curriculum), MIKID, Parenting Arizona, NAZCARE, and OCSHCN. NARBHA's Family Leadership Committee is developing a plan to provide compensation for family members who receive this training when, and if, it is not covered by their employer. Family member training will be tracked by NARBHA staff. This training will serve as a first step in the process of developing a group of family members who will be available for paid and voluntary family support positions for adults and children within NARBHA's GSA.

Mobile Crisis

- Mobile Crisis is available throughout NARBHA's GSA. Each Service Area Agency (SAA) has qualified staff dedicated to providing Mobile Crisis Services (H2011) during both regular business hours and after hours. After hours Mobile Crisis Services are provided by staff who are on-call and available to provide mobile crisis services based upon the presenting needs of the clients. In addition to the numbers of dedicated staff available to provide mobile crisis services, identified in Attachment C, there are also on-call supervisors and medical practitioners to support and, if necessary, accompany the dedicated clinicians in mobile crisis service delivery; these on-call supervisors and medical practitioners were not included in the FTE counts in Attachment C.

Prescriber Capacity

- NARBHA's Minimum Units are for all outpatient services only. NARBHA plans to increase prescriber involvement in Child and Family Teams as well as increase the penetration rate of eligible members. NARBHA prescribers have a larger outpatient service role than just medication assessment and prescribing. They also participate on Child and Family Teams, coordinate care, supervise and assist clinical staff, provide consultations for primary care physicians, provide emergency psychiatric services, provide follow-up visits for post-inpatient discharges, and provide walk-in "urgent care" psychiatric services for members at risk for lapses in medication or provider continuity.

Therapeutic Foster Care (TFC)– Child

- Recently, NARBHA greatly expanded, the number of beds for TFC beds in its Provider Network.
- NARBHA recently has expanded residential treatment options (Level II Therapeutic Group Homes) to enable adolescents to receive treatment in the least restrictive environment capable of meeting their needs.
- NARBHA will continue to expand TFC beds, as described in Attachment 2C and question 2g.

Therapeutic Foster Care (TFC) – Adult

- Based upon a recent NARBHA consumer survey, 81% of respondents (n=48) indicated that living with a foster family would not be a good housing option to meet their needs.
- TFC, when identified by a treatment team, is provided outside NARBHA's GSA; in the last year one member received this service. NARBHA has a FFS contract with Devereux to meet this need.
- Based on member input and low demand, NARBHA instead meets member needs through housing supports.

Sub-acute Psychiatric and Detoxification – Child

- NARBHA subcontracts for inpatient services within and outside of its GSA to ensure that member needs are appropriately met. Please see the footnoted information in Attachment C.

Residential Treatment Center (RTC)

- NARBHA subcontracts for RTC services within and outside its GSA to ensure that member needs are appropriately met. Please see the footnoted information in Attachment C.

Supported Housing

- NARBHA has recently expanded supported housing options as part of its ADHS/DBHS approved Network Sufficiency Plan. In 2003 NARBHA added 8 beds of 24/7 supervised housing in Flagstaff; 4 beds in Apache Co., 14 beds in Prescott/Prescott Valley; 8 beds in Kingman; and 6 beds in Holbrook. During 2004 NARBHA completed a 5 unit 10 bed housing complex in Page and received a grant from the State Housing Authority to build 5 units and 10 beds of supported housing in Holbrook.
- In addition to the Supported Housing that NARBHA funded or assisted in establishing, SAAs provide extensive housing assistance to members through housing obtained in the private market. These services are typically billed/encountered as case management services and include assisting members in finding affordable housing, handling rent and utility payments, managing household chores, and assistance in roommate relationships.

Clarify the number of Inpatient Children's Beds within the GSA and the number out of region

- Please see the footnote on Attachment C

Clarify the number of pharmacy sites within the GSA

- NARBHA has 50 pharmacies within its GSA and 653 statewide, outside its GSA, which NARBHA believes exceeds the minimum number of pharmacies necessary to meet member needs.

Volume 2, Item g – Limit 3 pages.

- **Based on changes to Volume 2, item c, resubmit how the Offeror will secure the needed providers by Geographic Service Area to begin the contract with sufficient providers.**

Based upon the information provided and footnoted in Attachment C and the assumptions described in question 2d, NARBHA will begin the contract with sufficient providers as described below:

Sub-acute facilities for children and adolescents:
As described in the footnote to Attachment C, NARBHA uses Level 1 Psychiatric Acute Hospitals and Level 1 RTCs, rather than sub-acutes, for children and adolescents with inpatient needs. Based upon this, NARBHA believes that the number of subacute beds for children and adolescents is sufficient, when considered with the number of hospital and RTC beds available for children and adolescents.

Inpatient Services - Psychiatric Acute Hospital
Please refer to the footnoted information in Attachment C. NARBHA believes that the current number of inpatient beds is sufficient to meet the needs of members who are children and adolescents.

Residential Treatment Center
Please refer to the footnoted information in Attachment C. NARBHA recently added 16 RTC beds within its GSA as part of its 2004 Network Sufficiency Plan that has ADHS/DBHS approval and oversight. NARBHA believes that the current number of RTC beds is sufficient to meet the needs of members who are children and adolescents.

Therapeutic Foster Care – Adult Placements
NARBHA has a fee-for-service contract with Devereux for access to Devereux's approximately 10 Adult Therapeutic Foster Care Beds. Based upon a 2004 NARBHA survey of consumers, 81% (n=48) of respondents indicated that adult therapeutic foster care was not a housing option that would meet their needs or be a desirable option. During 2004 one NARBHA member accessed Deveruex's adult therapeutic housing. Based upon consumer input, NARBHA has focused Provider Network expansion in supported housing and providing case management to members living in private housing. NARBHA will continue to study the need for this placement option, however, based upon consumer input, low utilization, and the availability of alternative housing and support options, NARBHA believes that its current amount of therapeutic foster care placements for adults is sufficient to meet member's needs and expressed preferences.

Therapeutic Foster Care – Child Placements
By July 1, 2005, NARBHA will increase child therapeutic foster care beds by adding 5 beds. The addition of these beds will be achieved by working with providers who are currently in the process of recruiting, screening, training, and licensing families that provide these services. The development of quality therapeutic foster care beds for children takes a great deal of planning, community outreach, training, assistance, and oversight. NARBHA works closely with DES and its two providers of therapeutic foster care for children, Catholic Social Services and Human Resource Training (HRT).

Recognizing that the development of quality foster care homes for children is very involved and challenging, and does not occur in a short period of time, and recognizing that therapeutic foster care beds are a desirable option to meet the needs of children and adolescents, NARBHA is committed to expanding the number of therapeutic foster care options for children beyond July 1, 2005. Therefore NARBHA intends to do the following: by 12/31/05: NARBHA will expand its beds by 7 to a total of 50 (2 in Mohave County, 3 in Navajo County, and 2 throughout the region); by 07/01/06 NARBHA intends to expand its beds to 60 (an additional 4 in Mohave County, 2 in Navajo County, and 4 region-wide); by 12/31/06 NARBHA intends to add an additional 5 beds in the region for a total of 65 beds. This represents a 71% increase over current beds.

NARBHA will achieve this expansion by continuing to work with DES subcontracted providers, Catholic Social Services, and HRT, and will also partner with Daybreak, an experienced quality provider of residential children's services in Northern Arizona. The Daybreak partnership represents an expansion from NARBHA's current providers and also a deviation from using only DES providers.

Housing

In addition to the significant expansion of supported housing that NARBHA established in 2003, as described in the answer to question 2b, NARBHA has continued to expand supported housing throughout its GSA, as approved and monitored by ADHS/DBHS, in NARBHA's 2004 Network Sufficiency Plan. With the 2004 expansion of housing (8 beds in Page and the award of a grant from the State Housing Department and DBHS funds for 10 beds in Holbrook), NARBHA members will have access to over 350 beds of supported housing or halfway house beds. In addition, case managers at NARBHA's Service Area Agencies (SAAs) provide extensive housing assistance to members who receive housing in the private market. This includes assisting members to find and obtain affordable private housing, handling rent and utility payments, managing household chores, and assistance in roommate relationships. Unfortunately the data that documents this extensive assistance in obtaining and maintaining housing is not always captured because most of this housing assistance is encountered/billed as case management, as shown by NARBHA reviews of provider records that occur through data validation and related record reviews. Based upon NARBHA having over 350 beds of supported housing and halfway houses in its GSA, the recent and ongoing expansion of supported housing that has been a part of NARBHA's 2003 and 2004 Network Sufficiency Plans under ADHS/DBHS approval and oversight, and the extensive housing assistance that is provided to NARBHA members as case management, NARBHA believes that it will have sufficient housing supports on 7/1/05 to meet member needs.

Pharmacy locations

NARBHA has 50 pharmacies within its GSA and 653 pharmacies statewide, outside its GSA. NARBHA believes that this number is more than sufficient to meet member needs.

Behavioral Health Recipients to deliver Peer Support services

As described in the answer to the question 2d, NARBHA has pioneered the development and expansion of Recovery in Northern Arizona through NAZCARE. Peer Support is provided by NAZCARE throughout Northern Arizona (Flagstaff, Show Low, Prescott, Cottonwood, Kingman) and continues to expand. NARBHA believes that the minimum amount of Peer Support delivered by recipients is sufficient, given the current stage of development of this service, and based upon the availability of the service in each sub-geographic area throughout NARBHA's vast GSA. Through extensive and ongoing work with NAZCARE, NARBHA has made this service available throughout its GSA. By July 1, 2005, NARBHA will continue to work with NAZCARE to support the current members who provide these services and to increase that number of providers by 2 FTEs and 10 part-time volunteers.

The next step in NARBHA's ongoing and demonstrated commitment to Recovery is to assist and support NARBHA's SAAs in hiring (or using volunteers) to provide Peer Support. Based upon NARBHA's experience with NAZCARE, input NARBHA has sought and received from other Recovery providers in Arizona (specifically, META), and technical assistance provided to NARBHA by ADHS/DBHS, NARBHA has learned that to successfully implement Recovery with its SAAs a great deal of planning, support, and outreach will need to occur. NARBHA has already brought in META Services Inc. (META) to conduct a half-day training with the Directors of the SAAs and more training and assistance is planned. Part of the planning and support that will need to occur at SAAs will be conducted by NARBHA staff whose primary job responsibility is to implement Recovery in each SAA; NARBHA will be hiring at least one additional staff person to conduct this next phase of Recovery implementation. By 7/1/06, in addition to the added staff and volunteers supported by NAZCARE, NARBHA intends to have Peer Support provided by recipients at each SAA.

Family members to deliver Peer Support

NARBHA will continue to expand Recovery throughout its GSA and into its SAAs. As described above for "behavioral health recipients to deliver peer support" NARBHA is committed to effectively providing peer support by ensuring that the SAA staff understand and embrace Recovery; that family members and recipients are recruited appropriately; that specialized training is developed and provided; that there are sufficient and effective supports for the recipients and family members who deliver these services; and that issues that are particularly relevant to small towns are addressed, such as where and how family members and/or recipients receive services to support their own Recovery.

As NARBHA continues to expand its services delivered by family members, the NARBHA Family Leadership Committee will identify family members who are interested in providing family support. These family members will be provided with a choice of training opportunities provided by agencies such as NAMI (using the *Family to Family* curriculum), MIKID, Parenting Arizona, NAZCARE, and OCSHCN. NARBHA's Family Leadership Committee is developing a plan to provide compensation for family members who receive this training when, and if, it is not covered as part of an understanding with their employer. Family member training will be tracked by NARBHA staff. This

training will serve as a first step in the process of developing a group of family members who will be available for paid and voluntary family support positions for adults and children within NARBHA's GSA.

Mobile Crisis

Based upon the information in Attachment C and in the answer to the question in 2d, NARBHA believes that it has sufficient staff throughout its region to provide mobile crisis services.

Prescriber Capacity

The NARBHA provider network has two additional FTEs (1 full-time and 2 part-time prescribers) who will have started employment as of July 1, 2005; an additional FTE is in the final stages of hiring.

NARBHA continues to actively support recruitment efforts by the SAAs/TAAs in an ongoing process to ensure adequate prescriber availability and penetration into communities to ensure medication availability and adequacy of evaluation and treatment. NARBHA has a Medical Practitioner Recruitment Plan which includes early personal contact to prescriber inquiries by the NARBHA Medical Director or Associate Medical Director, targeted internet web and journal advertising, visits to University of New Mexico Rural Psychiatry programs, Banner Behavioral Health Residency programs, and telemedicine presentations.

Volume 2, Item l – Limit 1 page.

- **Discuss Offeror's clinical oversight of consumer run drop-in centers.**

NAZCARE provides Peer Support Services at five sites in Northern Arizona: Prescott, Kingman (beginning March 1, 2005), Show Low, Flagstaff, and Cottonwood. Additional support is provided through a consumer operated telephone Warm Line. NAZCARE's drop-in centers are managed on a day-to-day basis by Center Managers who are consumers, and are supervised by staff out of the NAZCARE office in Prescott. The CEO of NAZCARE is a Licensed Baccalaureate in Social Work (LBSW) with 41 years of experience working with persons with serious mental illness. The five drop in sites and their Center Managers are managed by two NAZCARE Clinical Supervisors, one of whom is a consumer with previous experience as a Center Manager; the other has a Masters degree in a clinical field with over 20 years of relevant experience. These two Clinical Supervisors meet with Center Managers on a weekly basis, as well as attend each Center's monthly "membership meeting." Both the Clinical Supervisors and the NAZCARE CEO are on call (24/7) for any emergent clinical and/or management concerns. This on-call coverage includes backup to the NAZCARE Warm Line for any clinical concerns which may arise. The Clinical Supervisors receive supervision from NAZCARE's CEO who meets with each of them individually once a week for an hour (minimum), and weekly for an additional hour and a half as a team.

NAZCARE works very closely with each of its members' clinical service providers (Service Area Agencies) and has policies which lay out the manner in which member care is coordinated. During the referral process NAZCARE staff become familiar with the Peer Support needs of each member. Staff is trained via required in-service education, which is documented in personnel files. As an additional safeguard, each NAZCARE employee and volunteer develops a Wellness Recovery Action Plan (WRAP) for themselves. Like an advance directive the WRAP specifies exactly what type of support they request for themselves in order to avoid decompensation, or in case they or others notice the need for behavioral health intervention. Employees are encouraged to file this WRAP with their treatment team.

NARBHA's Clinical Operations staff meets with NAZCARE's CEO and supervisors on a monthly basis in order to discuss issues related to programming. NARBHA's Adult Projects Supervisor is the liaison for NAZCARE at the NARBHA level; however the Adult Services Manager and the Director of Clinical Operations are always available to offer technical assistance and guidance if a higher level of involvement is needed – particularly in the area of program development. If NARBHA receives any sort of clinically oriented issue resolution or complaint related to Peer Support services, Clinical Operations staff aid in the investigation of the complaint and offer technical assistance to NAZCARE staff.

Volume 2, Item m – Limit 1 page.

- **Confirm that continuity of care transition for recipients reaching the age of majority will be applied to all youth.**

NARBHA confirms that continuity of care transition for recipients reaching the age of majority will be applied to all youth.

Volume 3, Item a – Limit 1 page.

- **Confirm that bureaucratic processes related to choice in providers, including requirements to put requests in writing and CEO approval of requests, are removed.**

Each NARBHA enrolled member is assigned to a NARBHA contracted Service or Tribal Area Agency (SAA/TAA), based upon their place of residence zip code. This system ensures that data and information are collected and allocated to providers appropriately, and assigns SAA/TAA responsibility to members for tracking purposes.

If a member requests or chooses services from providers who are not SAAs/TAAs, such as residential, specialty providers, or individual practitioners, the SAA or TAA is responsible for arranging for the provision of those services. No administrative approval process or request to NARBHA is required.

If a member enrolled with one SAA/TAA requests or chooses to receive services at another SAA/TAA, a simple process is required. The member or provider, on their behalf, contacts NARBHA Member Services in writing or via telephone, and requests services elsewhere. This request, most frequently, is because of geography (the member lives closer to another SAA/TAA), or may be due to a conflict of interest with their home SAA/TAA. The Member Service staff evaluate the request, including the requestor's need for transportation, and make a decision regarding the request. They are then responsible for re-assigning the member to another SAA/TAA in the data system, so that the new SAA/TAA is identified and held accountable for services and data submission to NARBHA.

If a member presents at an SAA/TAA at which they are not currently enrolled and requests services, services can be provided without approval by NARBHA. The SAA/TAA assignment will be changed subsequently.

This process has been streamlined so as to limit barriers for members, while at the same time retaining accurate data tracking and data submission requirements for NARBHA and its provider network.

Volume 3, Item c – Limit 1 page plus Provider Manual text.

- **Discuss in detail how mobile crisis services and crisis lines will respond to behavioral health crises. Discuss how Offeror will ensure that 911, law enforcement and paramedics are not inappropriately relied upon to respond to behavioral health crises. Provide Provider Manual text that will support this.**

Community Information and Availability

Crisis services are provided to a person for the purpose of stabilizing or preventing a sudden, unanticipated, or a potentially deleterious behavioral health condition, episode, or behavior. For the purpose of responding to such crises, NARBHA maintains a toll free telephone number, which is listed in telephone directories throughout NARBHA's Geographic Service Area. This toll free line will be answered 24 hours a day, seven days a week by staff at ProtoCall. If the member contacts the Service Area Agency (SAA) directly, either via telephone or by walking in, the same requirement for availability is maintained.

Crisis Triage and Mobile Crisis Services

A behavioral health crisis shall be assessed to identify the potential risk of harm to self or to others, urgency of need for behavioral health services, and type/level of services needed to resolve the crisis. Crisis Triage typically occurs by telephone, however the need for Face to Face Crisis Triage may occur as a result of a "walk-in" to a SAA or at any point during treatment when potential risk factors become known or apparent to members of the treatment team.

During the process of conducting either a Telephone or Face to Face Crisis Triage, members are typically able to receive the support and assurance that they need to be referred back to their treatment team for follow-up. When a non-enrolled person calls or walks in for crisis services, Crisis Triage is an effective tool for connecting with and engaging this person.

Service Area Agency staff (during business hours) provides both Telephone and Face to Face Crisis Triage. ProtoCall staff (after business hours) provide Telephone Crisis Triage and determine whether the member's needs are low, high, or imminent. ProtoCall is not required to contact staff at SAAs regarding members with low acuity whose immediate needs have been handled during the Telephone Crisis Triage; however reports are forwarded to the SAAs by the next morning. Members with high acuity must be referred immediately by ProtoCall to on-call staff at the SAAs for Mobile Crisis services. In the event of an imminent situation, ProtoCall takes appropriate action, contacting 911, keeping member's safety and public safety as a priority. SAA staff are contacted as soon as the situation is assured safe and the condition has stabilized.

NARBHA Requirements

NARBHA has set standards for the manner in which SAAs respond to crisis situations. The proposed text, which will be incorporated into NARBHA's policy on *Crisis Triage and Mobile Crisis Services*, follows on the next page of this response.

Provider Manual Text
Specific to Crisis Triage and Mobile Crisis Services

I. Types of Crisis Services

NARBHA requires that appropriate behavioral health services will be arranged or provided to members in crisis, based on acuity and assessed level of potential risk. Types of Telephone and Mobile Crisis services include:

- Telephone or face-to-face crisis triage
- Mobile Crisis - Client Home (Provider staff only)
- Mobile Crisis - Client Home (Two person team)
- Mobile Crisis - Client Home (Provider staff accompanied by Police Officer)
- Mobile Crisis - Emergency Room Transport
- Mobile Crisis - Other location

Crisis Triage may also occur any time during the course of a member's treatment as a result of either self-report or by the report of others.

II. Content Requirements for Telephone or Face-to-Face Crisis Triage

Crisis Triage will contain at a minimum, the following elements, along with a rating scale capable of determining both low and high levels of acuity. Staff must be trained to use the tool to determine when the member's need is imminent. Elements must include:

A. Identifying Information:
1. Member name, telephone number (from which they are currently calling), and age
2. Enrollment status
3. Date and time of call
4. Notation of whether triage assessment was performed face-to-face or over the telephone

B. Present Situation:
1. Currently alone
2. Recent loss (partner, job, death, illness, residence, etc)
3. Current symptoms of psychosis, disoriented, or disorganized thinking
4. Current medical issues
5. Level of depression
6. Level of anxiety
7. Level of isolation from others
8. Intensity of hostility
9. Level of hope
10. Currently intoxicated or impaired by drug use
11. Support system
12. At risk of being harmed by another

C. History
1. Psychosis
2. Inpatient psychiatric hospitalizations
3. Family suicide attempts
4. Medical issues
5. Domestic violence
6. Drug/alcohol use/abuse

D. Suicidal Ideation (no reported thoughts; thoughts in last six (6) months; having active thoughts)
1. When (in the past, in the future, in a few hours, immediately)
2. Intent (uncertain, actively planning, actively pursuing)
3. Method (unclear, has plans, well planned)
4. Available means (unavailable, has nearby, has in hand or is using)
5. Has recently or in the last year given away possessions or made a will
6. Previous suicide attempts within the last year or within the last 30 days

E. Homicidal Ideation (no reported thoughts; thoughts in the past six (6) months; having active thoughts)
1. When (in the past/in the future, in a few hours, immediately, names of groups or individuals)
2. Where (unplanned, clear plans, is at location)
3. Intent (uncertain, actively planning, actively pursuing)
4. Method (unclear, has plans, well planned)
5. Available means (unavailable, has nearby, has in hand or is using)
6. Previous history (none, history of threats, history of danger to others)

III. Dispositional Planning

If the member is known to the Service Area Agency or to ProtoCall, the staff completing the Crisis Triage must take into consideration what has worked well for the member in past situations. This consideration must also include any type of WRAP (Wellness Recovery Action Plan) the member may have worked out with their Clinical Liaison and/or any other type of Safety or Crisis plan developed by the member and his/her Child and Family or Adult Team.

A. Imminent danger to self or others (currently in a life threatening medical or psychiatric situation that, if not treated, may result in serious morbidity or mortality):
1. Staff must conclude questioning immediately, keep the member on the telephone, or if on site, in their or another's close proximity and contact 911. If ProtoCall is conducting the Crisis Triage, they should not delay emergency services to the member by calling the on-call Mobile Crisis staff at the Service Area Agency, but should call them after 911 has been contacted.
2. Staff should be able to assist the emergency responders by providing critical information such as:
   a. Type of emergency (gunshot wound, overdose, etc)
   b. Condition of member (not breathing, violent, etc)
   c. Address, including major cross street and apartment numbers
   d. Telephone call-back number
   e. Whether there is a weapon on the scene
3. Crisis staff are required to complete a Duty to Warn when members indicate imminent danger to others.
4. Once the member is in a safe, professionally supervised and contained location, staff will complete a full crisis assessment
5. If it is determined that the member is in need of admission to a psychiatric facility, staff will make arrangements for admission to a psychiatric facility

B. High level of acuity:

Examples of Mobile Crisis services provided to members with high acuity include:
1. Mobile Crisis - Client Home (Provider staff accompanied by a Police Officer). There may be times that a member's needs are not imminent; however the safety of others may be an issue. Members in this type of situation do not require assistance from emergency personnel, however because risk factors identified on the Crisis Triage determine that the member is dangerous to others, a Police Officer would be asked to accompany the staff to the member's home.
2. Mobile Crisis - Client Home (Two person team). Two person teams should be utilized when a member does not demonstrate evidence of danger to others on the Crisis Triage; however, because of their high acuity a second staff person would be required to be present.

C. Low level of acuity:

Examples of Mobile Crisis services provided to members with low acuity include:
1. Mobile Crisis – Client Home (Provider staff only) and Mobile Crisis – Other Location. When Crisis Triage indicates that the member does not demonstrate a high level of danger to self or others, crisis services staff are required to complete a crisis assessment in a location that is comfortable for the member and his/her family. Examples of such locations may be: the member's home, school, church, friend's or family's home.
2. Also falling under the classification of Mobile Crisis – Other Location would be a jail or a hospital emergency room request for a crisis assessment.

IV. Documentation

A. Service Area Agency staff are required to make notation of their rationale for the type of Mobile Crisis Service delivered and their choice of location.

B. Crisis services shall be documented in compliance with licensure rules and ADHS/DBHS policy. These standards apply to both enrolled and non-enrolled individuals who present for Crisis Triage and/or assessment.

C. For Title XIX eligible members, upon delivery of a covered behavioral health service, including crisis services, the person must be immediately enrolled in the behavioral health system and the effective date of enrollment must correspond with the date on which the first service was received (see NARBHA Provider Manual, 7.5, Enrollment, Disenrollment and Other Data Submission).

D. Persons who receive telephone Crisis Triage only are not required to be enrolled.

E. All Service Area Agencies are required to document the results of a crisis assessment by completing as much of the ADHS/DBHS Core Assessment and Addendums as are appropriate to the crisis situation. A detailed completion of the "Next Steps" section of the ADHS/DBHS Core Assessment is essential to document necessary follow-up services.

Volume 3, Item d – Limit 2 pages.

- **Discuss what the Offeror will require of providers relative to clinical supervision. Discuss specifically what the Offeror will review in monitoring for quality clinical supervision.**

NARBHA's Service Area Agencies are required to follow the regulations in Arizona Administrative Code R9-20-205, which describes the requirements for clinical supervision. Providers have developed tracking forms, which are reviewed by the Office of Behavioral Health Licensure during their site reviews and by NARBHA during its Human Resources Monitoring.

In addition to these "base line" requirements, NARBHA recognizes that supervision must be individualized and in line with Arizona's Behavioral Health Vision and Principles. NARBHA continues to train its providers on all of the ADHS/DBHS Clinical Practice Guidelines, as well as new initiatives such as Transition to Adulthood, Adult Teams, etc. NARBHA recognizes that, although training is necessary to set the tone for clinical direction, there is a limitation to the amount of benefit that can be derived from training alone. Supervision needs to be delivered in a quality manner in order for clinical staff to provide services that allow Northern Arizona's system of care to move to the next level, based on Best Practices. Therefore NARBHA proposes to monitor for quality clinical supervision in the following ways:

- Tracking and profiling of work quality of Clinical Liaisons

  ADHS/DBHS' Independent Case Review (ICR) and NARBHA's Case File Review (CFR) are essential components in the development of a process, which enables NARBHA clinical staff to obtain individualized results that reflect progress (or the lack thereof) towards meeting ADHS/DBHS standards. NARBHA has created a method for tracking poor performance on the ICR/CFR to each member's Clinical Liaison. This enables NARBHA to track and profile these individual staff members.

  NARBHA's Director of Clinical Operations has utilized the ability to track and profile individual staff members to formulate Performance Improvement Plans using the Plan, Do, Check, Act (PDCA) model which target performance on the four ADHS/DBHS standards, Comprehensive Assessments and Treatment Recommendations, Cultural Preferences in Assessments and Treatment Planning, Follow-up After Missed Appointments, and Family Members Involvement in the Treatment Planning Process, which did not meet clinical standards during the last Administrative Review. These PDCAs include plans to target improvement activities with SAAs/TAAs that perform below minimum performance standards. Clinical Liaisons responsible for member charts that fail to meet these standards will be identified based on the NARBHA CFR 2004 results.

  NARBHA proposes to develop a performance profile for each Clinical Liaison based on CFR chart scores. Supervisors at each SAA/TAA where deficiencies are noted will be required to perform a peer or supervisory review of a sample of charts reflective of the population, which is specific to the standard that is not being met. Subsequent supervision, coaching, and mentoring specific to the individualized need of the selected Clinical Liaisons will be required.

- Tracking and profiling of work quality of medical practitioners

  NARBHA's Medical Director has developed a method for profiling medical practitioners by conducting periodic reviews of medication prescribing patterns on all children and adolescents who receive medications. When NARBHA identifies prescribers who are not following the practice guidelines set forth in the ADHS/DBHS Practice Improvement Protocol on *The Use of Psychotropic Medications in Children and Adolescents*, letters of concern and corrective actions are sent to these prescribers. Results have indicated a significant decline in the over-utilization of medications.

  These same practitioners are profiled on the use of intraclass and interclass polypharmacy ADHS measures per the SAMHSA Evidence Based Practice on Medication Management Approaches in Psychiatry and DBHS' policy on Medication Use. NARBHA's medical staff review aggregated data, which includes member specific and physician-specific information. Outlying medical practitioners have received intensified peer review and polypharmacy education, which has resulted in a dramatic decrease in specific types of polypharmacy.

Efforts such as those outlined above will form the basis for continued efforts at supervision that is individualized, specific to the area of need, and in concert with a system of care, which is committed to the delivery of behavioral health services in line with the Vision and Principles set forth in the RFP.

Volume 3, Item e – Limit 1 page.

- **Discuss what efforts will be made to involve family members of adults in assessment and service planning.**

NARBHA recognizes the importance of family member involvement in the assessment and service planning process and has, for several years, provided ongoing technical assistance and training to SAA/TAA staff. Included are several different training opportunities and roll play demonstrations on DVD.

On November 9, 2004, NARBHA re-trained its providers on *Family Involvement in the Service Planning Process*. This training emphasized the importance of engaging family members, the role of the Clinical Liaison, proper documentation, a review of nine different ways that family members bring accumulated knowledge to the Adult Team process, dealing with family member resistance, the importance of the family's culture and unique family differences, and the importance of seeking out strengths within each individual's family.

In the past, providers have voiced concerns related to confidentiality. As a result of the ADHS/DBHS technical Assistance Document – *Information Sharing with Family Members of Adult Behavioral Health Recipients* – NARBHA is able to offer additional clarification to providers via an upcoming training on March 8, 2005 on this very important aspect of working with the families of adult members. Engaging family members who are actively participating in a member's care is an important part of the assessment, treatment, support, and recovery process.

Another Clinical Guidance Document – *Transitioning to Adult Services* – has been introduced to providers, however NARBHA intends to train again on February 23, 2005 - this time involving providers, community members, advocates, stakeholders, and family members - on the crucial role that families play in the transition of their children into the adult system of care. The *Transitioning to Adult Services* Practice Improvement Protocol is clear about the fact that: "*Families of children with special needs have often been actively involved in every aspect of their child's life. Redefining the role of the family is an important task in the child's gradual move toward self-sufficiency*."

This same region-wide training will focus on the ADHS/DBHS Practice Improvement Protocol on *Adult Clinical Teams*. Didactic and Experiential learning opportunities will focus on the importance of promoting effective family involvement by:

- Emphasizing the Clinical Liaison's role in engaging family members in assessments, service planning, service provision, and service plan monitoring.
- Securing an effective response to crisis or immediate needs of the member/family.
- Scheduling team meetings at times/locations of the member/family's preference
- Exercising cultural and linguistic expertise (such as arranging for interpreter services), providing peer and/or family support services or other assistance, and identifying and helping to address and resolve other potential barriers to active participation of the person and his/her family members.
- Identifying, assessing, and recording the member's and family's strengths, and respecting each family's unique style of coping and adjusting to stress.
- Identifying the member's and family's goals, and their descriptions of needs for behavioral health supports and/or services needed to reach those goals, and participating with the member and family in developing appropriate supports and service options.
- Communicating with family members on a regular basis in a manner consistent with the Technical Assistance Document on information sharing.
- Recognizing the family members can assist in protecting the member's rights and effectively voicing support and service needs.

NARBHA intends to closely monitor results from ADHS/DBHS and internal chart reviews related to standards on family involvement of adult members in the assessment and service planning process. A provider profile will be developed by NARBHA for each Clinical Liaison based on their chart scores. Supervisors at each SAA/TAA where deficiencies are noted will be required to perform a peer or supervisory review of a sample of charts and subsequent supervision, coaching, and mentoring, which is specific to the individualized need of the identified Clinical Liaisons, will be required.

Volume 3, Item g – Limit 1 page.

- **Discuss expectations for prescriber involvement in the Child and Family Team (CFT) process consistent with hours proposed in Volume 2, item c.**

Prescribers are members of the Child and Family Team. Prescribers are expected to participate in the Child and Family Team process whenever identified and invited by the child, family, or other team member; or whenever the objectives identified for the individual child include need for prescriber involvement in the CFT process.

Service and Tribal Area Agencies (SAAs/TAAs) are NARBHA's key community-based comprehensive behavioral health services providers. Prescribers perform comprehensive psychiatric evaluations and actively solicit input from CFT members. Prescribers support the CFT by educating CFT members, in easily understandable language, on prognoses, evidence based practices, risks and benefits of medication treatments, and treatment options for youth.

When medications are considered or recommended, prescribers and CFT members collaborate to ensure:

- the safety and effectiveness of the medication regimen through verbal and written informed consent;
- clearly defined target symptoms;
- regular monitoring for responses and adverse effects;
- coordination of care with other providers and stakeholders; and
- on-going psycho-education.

NARBHA's SAA/TAA prescribers, along with other provider staff, were trained in CFT practices and understand and follow the ADHS/DBHS Practice Improvement Protocol (PIP) The Use of Psychotropic Medication in Children and Adolescents, and the ADHS/DBHS Informed Consent standards. On the 2003 ADHS/DBHS Independent Case Review (ICR) NARBHA scored the highest of any Regional Behavioral Health Authority (RBHA) in the state for children, for the performance standard relating to informed consent covering new medications. NARBHA met the ICR standard. In the 2003 ADHS/DBHS Youth Services Survey for Families, 96.7% of parents of NARBHA child members reported giving consent for medications prescribed.

Increase in prescriber capacity to meet increased penetration rates and increased number of Child and Family Teams.

- NARBHA has included this expectation of prescriber participation in the hours dedicated to outpatient services beyond medication assessment and prescribing, as per the Best and Final Offer Attachment C.

Volume 3, Item j – Limit 3 pages.

- **Describe how the Offeror will meet requirements of Scope of Work G.10. Discuss how Offeror will provide substance abuse services of sufficient scope, duration and intensity for adults and children to achieve outcomes identified in G.10 and the DHS Minimum Performance Standards. Discuss how Offeror will address the needs of intoxicated persons, including off reservation Native Americans who do not require the services of a Level 1 facility.**

Service Delivery

NARBHA's provider system delivers substance use disorder services and supports that are designed to reduce the intensity, severity, and duration of substance use, prevent relapse, and promote recovery. Re-engagement of members is individualized and approached in a culturally competent manner with families included in the treatment process when appropriate. NARBHA's provider system includes an array of substance abuse treatment services, including outpatient substance abuse treatment; intensive outpatient treatment; and substance abuse residential treatment. Members in NARBHA's system are encouraged to maintain employment or return to the workforce and are:

- Assessed for co-occurring mental health conditions and physical disability/disease
- Provided with physician oversight of medical treatment, including methadone, medications, and detoxification
- Provided with services by staff competent to assess and treat substance use disorders in individuals and families
- Ensured coordination and continuity within and between behavioral health service providers and natural supports to reduce premature discharge or disenrollment

Substance Abuse Prevention and Treatment (SAPT) Block Grant Requirements

NARBHA ensures that services funded under the federal block grants meet all requirements outlined in the Special Terms and Conditions paragraph F.10, Management of Block Grant Funds, and the ADHS/DBHS/NARBHA Provider Manual. Members have the right to receive services from a provider to whose religious character they do not object. NARBHA's SAPT providers notify members of this right and provide documentation of this notification in the member's record. NARBHA recognizes the following as priority populations:

- Women and teenagers with young and dependent children and their families
- Pregnant women and teenagers who use substances
- Persons who use drugs by injection
- Persons vulnerable to HIV

NARBHA provides primary prevention services to individuals and families in its GSA who do not require covered behavioral health services.

A. Services for Women, Children, and Families

NARBHA provides services and support to engage, retain, and treat pregnant women and women/teens with dependent children needing substance abuse treatment. Services are focused on long-term recovery, including outreach, supported employment, coordination of housing needs, delivery or referral for primary medical/pediatric care for women and children, gender specific substance abuse treatment, therapeutic interventions for children, child care, case management, and transportation.

In the fourth quarter FY/04 NARBHA enrolled 106 substance abusing parenting women and 12 pregnant substance-abusing women. Of those, 93% received their assessment within the required time frames and 93% received their first treatment/interim services in a timely fashion. During this same quarter, all newly enrolled pregnant, substance abusing women received 100% of all required treatment services. Substance abusing parenting women received 88% of all required services.

- Preferential Access for Pregnant Women

  NARBHA's providers are required to abide by performance standards which are tracked and monitored for compliance with the requirement for service delivery within 48 hours. Any needed behavioral health service, including admission to a residential program if clinically indicated, must be provided to this priority population. If one of NARBHA's residential programs is unavailable, case mangers attempt to make a placement within another Geographic Service Area. If capacity still does not exist, NARBHA's member is placed on an actively managed list and interim services are provided until the member is admitted. Interim services include:

1. Counseling/education on HIV and Tuberculosis (including the risks of transmission)
2. The risks of needle sharing
3. Referral for HIV and TB treatment services if necessary
4. Counseling on the effects of alcohol/drug use on the fetus
5. Referral for prenatal care

- Services for Women and Children

NARBHA works collaboratively with providers through the Arizona Families First (AFF) Program. Referrals are made to the appropriate provider and members who are SMI or pregnant are assessed regardless of funding source. NARBHA collaborates closely with Child Protective Services and regional Arizona Families First providers to insure that programs are consistent with ADHS/DBHS Clinical Guidance Documents and policy.

In partnership with other local community agencies who have housing as their mission, NARBHA continues to explore options to increase housing available in Northern Arizona for substance abusing women and children. Examples of this type of partnership include NARBHA's Service Area Agencies' (SAAs) relationships with Old Concho in Navajo and Apache Counties (90 units) and Sharon Manor (26 units) in Flagstaff. Both of these housing programs accept Title XIX and non-Title XIX substance abusing women and their dependent children.

B. Services for Persons who use Drugs by Injection

NARBHA's providers are required to provide services to behavioral health recipients who use drugs by injection within a timeframe indicated by clinical need, but no later than 14 days following the initial request for services/referral. In the fourth quarter FY/04 NARBHA enrolled 32 IV drug users. Of these IV drug users, 91% received referral to assessment in the required time frame and 97% received referral to first treatment service within the required time frame. During this same quarter, all newly enrolled IV drug users received 100% of all required treatment services.

C. Services for Members with Tuberculosis

NARBHA ensures that members with substance use disorders are referred for tuberculosis services.

D. HIV Early Intervention Services

NARBHA HIV funding is made available to SAAs who contract with a County Health Department for:

1. Provision of HIV risk assessments
2. Pre and post test counseling
3. HIV testing

Case Management and other supportive services are provided by both the SAAs and a County Health Departments.

E. Correctional Officer/Offender Program (COOL)

NARBHA's providers must abide by the requirement that members referred through the COOL Program receive a first treatment service 14 days from the date of referral. NARBHA serves the substance abuse treatment and behavioral health needs of high-risk offenders on adult parole by ensuring that expedited treatment services are provided. NARBHA has recently increased the expectation and job requirements of its COOL Liaison. This position has become a Licensed/Masters level position. Although the job requirements will continue to include tracking and monitoring, the COOL Liaison will provide an improved quality of technical assistance with a renewed effort towards examining program expectations. Additionally, NARBHA will continue to examine the quality of its COOL programs through two annual chart reviews, conducted in collaboration with ADHS/DBHS.

Detoxification Services

NARBHA, in concert with community groups throughout Northern Arizona, has developed a substance abuse service expansion plan which includes the development of detoxification services for persons not requiring the services of a Level I facility. This plan includes serving off reservation Native Americans in communities such as Flagstaff, Winslow, and Holbrook. The plan would be to establish social model detoxification centers with medical coverage in Flagstaff, Prescott, Verde Valley, Lake Havasu City, Bullhead City, Kingman, Winslow, Showlow/Pinetop, and possibly on the Hopi and Apache reservations. The plan would require local government participation of 20-30% of costs and tribal

participation where relevant. The model that NARBHA established in Page, Arizona, with ADHS/DBHS assistance and specific funding from the Legislature, is operating effectively.

Priority would be given to communities that demonstrate viable community partnerships towards solving the substance abuse detoxification and treatment needs and commit to long term cost sharing for the detoxification portion. Community partners should include city and county government, courts, probation departments, hospitals, health departments, and community health centers, if available.

A critical part of the plan is the expansion of treatment services to meet the needs of the additional consumers that would be brought into the system once these detoxification centers are up and running. The treatment system development would include a heavy emphasis on peer support, recovery, and diversion-based approaches in concert with courts, probation departments, and law enforcement.

Additional funding will be required from Title XIX, non-Title XIX, and local government and tribal sources to implement this plan. It is estimated that 60-70% of detoxification center costs and 70% of the treatment services will be Title XIX eligible.

If NARBHA is awarded the contract, NARBHA would request that this service expansion be considered in its Title XIX capitation rate negotiations. NARBHA is certainly open to a phase-in approach to this much needed service.

Volume 3, Item n

- **Clearly describe what services Offeror intends to prior authorize and submit the criteria that will be used to make the prior authorization decisions for each service.**

As per federal regulation and ADHS/DBHS requirements, NARBHA intends to continue to require prior authorization for Office of Behavioral Health Licensure (OBHL) Level I inpatient services (psychiatric acute hospitals, residential treatment centers {RTC} for person under age 21, and sub-acute facilities). Additionally, NARBHA intends to continue to require prior authorization for Level II Therapeutic Group Homes (TGH).

For admission to Level I facilities, NARBHA intends to use the criteria outlined by ADHS/DBHS as it currently exists or may be changed in the future. That criteria is attached to ADHS/DBHS/NARBHA Provider Manual Section 3.14. For ADHS/DBHS Admission to Inpatient Services Authorization Criteria, see attached PM Form 3.14.3. For ADHS/DBHS Continued Inpatient Services Authorization Criteria, see attached PM Form 3.14.4.

For admission to Level II Therapeutic Group Home facilities, NARBHA intends to continue to use the criteria formerly outlined by ADHS/DBHS. That criteria also is attached to ADHS/DBHS Provider Manual Section 3.14. For NARBHA Authorization Criteria for Level II Therapeutic Group Home Services, see attached PM Form 3.14.5. For NARBHA Continued Level II Therapeutic Group Home Services Authorization Criteria, see attached PM Form 3.14.6.

Medications:
NARBHA does not intend to require prior authorization of formulary medications.

Non-formulary medications may be requested by the prescriber directly to the NARBHA Medical Director/designee on a case-by-case clinical basis. Due to the comprehensive nature of the NARBHA Medication Formulary, which contains all of the currently utilized psychotropic medications in psychiatry, it is anticipated that this will be a rare occurrence. Prescriber assurance that the medication is a medically necessary behavioral health service is sufficient.

PM FORM 3.14.3
ADMISSION TO INPATIENT SERVICES AUTHORIZATION CRITERIA

A person must meet ALL criteria in Sections A., C., and D., and at least ONE of the criteria in Section B. for admission to inpatient services.

A. DIAGNOSIS

A specific diagnosis is not a condition for admission to an inpatient setting, however a specified diagnosis within the range of 290 through 316.99 is required to be documented at the time of discharge from inpatient services.

B. BEHAVIOR AND FUNCTIONING

1. Imminent risk of danger to self or others as a result of a behavioral health condition as evidenced by:
   a. Current suicidal ideation, behavior or intent,

   b. Current homicidal or significant assaultive ideation, behavior or intent, or

   c. Immediate physiologic jeopardy.

2. Disturbance of mood, thought or behavior which renders the person acutely incapable of developmentally appropriate self-care or self-regulation;

3. Disturbance of mood, thought or behavior that requires an assessment or medication trial that cannot be safely or adequately implemented in a less restrictive setting; or

4. Level of functioning that does not meet the above criteria, but less restrictive levels of care suitable to the behavioral health needs of the person are unavailable, or the person cannot return to his or her residence due to risk of harm to self or others due to a treatable behavioral health disorder, or there is a likelihood of imminent behavioral decompensation.

C. INTENSITY OF SERVICE

This type of service provides planned, comprehensive assessment or treatment involving close daily psychiatric supervision and 24 hour medical supervision.

Treatment should be in the least restrictive type of service consistent with the person's need and therefore should not be instituted unless there is documentation of a failure to respond to or professional judgment of an inability to be safely managed in an less restrictive type of service.

D. EXPECTED RESPONSE

1. The client's behaviors and symptoms, which were identified as reasons for admission, can be effectively treated by medically indicated treatment available in this setting.

2. The treatment can reasonably be expected to improve or stabilize the patient's condition so that this type of service will no longer be needed.

PM FORM 3.14.4
CONTINUED INPATIENT SERVICES AUTHORIZATION CRITERIA

A person must meet ALL criteria in Sections A and E, at least ONE of the criteria in each of Sections B, C and must meet Section D for continued stay in inpatient services.

A. DIAGNOSIS
A specified diagnosis within the range of 290 through 316.99 is required to be documented at the time of discharge from inpatient services.

B. BEHAVIOR AND FUNCTIONING
1. Emergence or continued evidence of symptoms which reflect imminent risk of danger to self or others as a result of a behavioral health condition, as evidenced by:

   a. Current suicidal ideation, behavior or intent, or
   b. Current homicidal or significant assaultive ideation, behavior or intent, or
   c. Ongoing physiologic jeopardy; or

2. Continued disturbance of mood, thought or behavior which renders the person acutely incapable of developmentally appropriate self-care or self-regulation; or

3. Significant regression of the person's condition is anticipated without continuity at this type of service.

C. INTENSITY OF SERVICE
There is documented evidence that the person requires at least one of the following:

1. Continued planned, comprehensive assessment or treatment involving close daily psychiatric supervision and 24 hour medical supervision. This may be as a result of a change in diagnosis, treatment failure, or newly-discovered aspect of the person's case necessitating a significant change in the treatment plan; or

2. Close, continuous, 24 hour skilled medical/nursing supervision of the person's behaviors, which are due to a behavioral health condition, in order to prevent injury to the person or others; or

3. Pharmacotherapy which requires continuous, skilled medical/nursing supervision for safe, effective use;

4. Skilled nursing observation and care in the management of disturbances of mood, thought or behavior which cannot be provided by non-medical personnel;

5. Repeated use of physical restraint; or

6. Inpatient services may be continued if the person no longer requires the type of service provided in an inpatient facility but there is not an available lower intensity of services suitable to the behavioral health needs of the person or the person cannot return to the person's residence because of a risk of harm to self or others.

D. RESPONSE
There is documented evidence that

1. Active treatment is provided that is reducing the severity of disturbances of mood, thought or behavior which were identified as reasons for admission; or

2. There has been a reevaluation and subsequent change in the treatment plan.

AND

3. There is still an expectation that continued treatment in this type of service can reasonably be expected to

improve or stabilize the patient's condition so that this type of service will no longer be needed.

OR

4. There is no less restrictive type of service available to safely meet the person's behavioral health needs.

E. DISCHARGE PLAN

There is a written plan for discharge with specific discharge criteria and recommendations for aftercare treatment that comply with current standards for medically necessary covered services, cost effectiveness, and least restrictive environment.

PM FORM 3.14.5
AUTHORIZATION CRITERIA FOR
LEVEL II THERAPEUTIC GROUP HOME SERVICES

A member must meet ALL criteria in Sections I, III, IV and V and at least ONE of the criteria in Section II for admission to basic residential treatment.

I. DIAGNOSIS

A specific diagnosis is not a condition for admission to an inpatient setting; however a specified diagnosis within the range of 290 through 316.99 (ICD9) is required to be documented at the time of discharge.

II. BEHAVIOR AND FUNCTIONING *(must meet one criteria)*

A. Recent, recurring or intermittent episodes of risk of danger to self or others as a result of a behavioral health condition, as evidenced by:

1. Suicidal ideation, behavior or intent, **or**
2. Homicidal or significant assaultive ideation, behavior or intent, **or**
3. Physiologic jeopardy;

OR

B. Disturbance of mood, thought or behavior which renders the patient acutely incapable of developmentally appropriate self-care or self-regulation;

OR

C. Disturbance of mood, thought or behavior that requires an assessment or medication trial that cannot be safely or adequately implemented in a less restrictive setting;

OR

D. Level of functioning that does not meet the above criteria, but less restrictive levels of care suitable to the behavioral health needs of the person are unavailable, or the person cannot return to his or her residence due to risk of harm to self or others due to a treatable behavioral health disorder, or there is likelihood of imminent behavioral decompensation.

III. INTENSITY OF SERVICE *(must meet <u>all</u> criteria)*

This level of care provides 24-hour supervision and a structured treatment program of partial care.

Treatment should be at the least restrictive level of care consistent with patient need and therefore should not be instituted unless there is documentation of a failure to respond to or professional judgment of an inability to be safely managed in a less restrictive level of care.

IV. EXPECTED RESPONSE *(must meet A <u>and</u> B criteria)*

A. The member's behaviors and symptoms which were identified as reasons for admission and which are consistent with the DSM diagnosis can be effectively treated by medically indicated treatment available at less restrictive type of service.

AND

B. The treatment can reasonably be expected to improve or stabilize the patient's condition so that this type of service will no longer be needed.

V. DISCHARGE PLAN

There is a written plan for discharge with specific discharge criteria and recommendations for aftercare that comply with current standards for medically necessary covered services, cost effectiveness, and least restrictive environment.

PM FORM 3.14.6
CONTINUED LEVEL II THERAPEUTIC GROUP HOME SERVICES AUTHORIZATION CRITERIA

A member must meet ALL criteria in Sections I and V, at least ONE of the criteria in each of Sections II, III and must meet Section IV for continued stay in basic residential treatment.

I. DIAGNOSIS

A specified diagnosis within the range of 290 through 316.99 (ICD9) is required to be documented at the time of discharge from inpatient services.

II. BEHAVIOR AND FUNCTIONING ***(must meet A or B or C criteria)***

A. Emergence or continuance of recent, recurring, or intermittent episodes of risk of danger to self or others as a result of a behavioral health condition as evidenced by:

1. Suicidal ideation, behavior or intent, **or**
2. Homicidal or significant assaultive ideation, behavior or intent, **or**
3. Physiologic jeopardy;

OR

B. Continued disturbance of mood, thought or behavior that substantially impairs developmentally appropriate self-care or self-regulation.

OR

C. Significant regression of the patient's condition is anticipated without continuity at this level of care.

III. INTENSITY OF SERVICE *(must meet A or B criteria)*

There is documented evidence that the patient requires at least one of the following:

A. Structured treatment, available on a 24-hour basis, to improve or maintain stability of mood, thought or behavior. The treatment is a medically indicated intervention, specifically targeted to the behaviors and symptoms that were identified as reasons for admission and which are consistent with the DSM diagnosis;

OR

B. 24 hour supervision of the patient's behaviors, which are due to,a behavioral health condition in order to prevent injury to the member or others.

IV. RESPONSE *(must meet A or B, and C or D criteria)*

There is documented evidence that:

A. Active treatment is provided that is reducing the severity of disturbances of mood, thought or behavior which were identified as reasons for admission; or

B. There has been a re-evaluation and subsequent change in the treatment plan.

AND

C. There is still an expectation that continued treatment at this level of care can reasonably be expected to improve or stabilize the patient's condition so that this type of service will no longer be needed.

OR

D. There is no less restrictive type of service available to safely meet the person's behavioral health needs.

V. DISCHARGE PLAN

There is a written plan for discharge with specific discharge criteria and recommendations for aftercare that comply with current standards for medically necessary covered services, cost effectiveness and least restrictive environment.

Volume 3, Item q – Limit 2 pages.

- **Discuss the specific commitments Offeror is making to provide training and technical assistance. Discuss the specific commitments Offeror is making regarding development of family involvement structures and co-location of services with CPS and other child-serving agencies. Describe the timeframe for adding new Therapeutic Foster Care beds.**

TRAINING AND TECHNICAL ASSISTANCE (TA)

Training and TA related to the seven Jason K (JK) Annual Action plan strategies will continue to be a high priority for NARBHA. NARBHA's current State Improvement Grant (SIG) plan, submitted to ADHS/DBHS, includes the commitment that the first year appropriation of $280,000 will be directed to support JK related activities. NARBHA will submit plans annually to ADHS/DBHS as required for future grants. Training and technical assistance commitments follow:

1. **Create sustainable and trusting partnerships with families and other child-serving systems**
   - NARBHA will continue to coordinate with ADES/Division of Developmental Disabilities (DDD) for the quarterly "Brown Bag Lunch Series" between local DDD and behavioral health personnel.
   - NARBHA will continue to work closely with ADES/Child Protective Services (CPS) on joint training and program development for children involved with CPS.
   - NARBHA has created the Family Leadership Committee, which consists of family members of consumers, to assist in ongoing practice improvement and systems change activities.

2. **Develop, train, and implement effective practice improvement protocols:** NARBHA personnel will train on new ADHS/DBHS Clinical Guidance Documents as they are released. Documents will be presented at the Regional Children's Council of Northern Arizona and to the Service Area Agencies/Tribal Area Agencies (SAAs/TAAs), which will be expected to train their staff and notify NARBHA of training efforts.

3. **Continue to train and coach system staff, partners, and families:** NARBHA is developing a comprehensive, computer-based training curriculum for Child and Family Team (CFT) facilitators. This training will be provided to all staff responsible for the provision of children's behavioral health services. The training will also be used by other stakeholder agencies to train their staff and by family members. Each training module will have set competencies, pre and post tests, activities, and clinical supervision requirements. Advanced modules will be required for facilitators of complex, multi-system cases and may include *Understanding the Unique Needs of Children in Foster Care* and *Working with the DD population.* A module on Clinical Supervision of Facilitators is being developed for managers.

   NARBHA has proposed contracting for a full-time trainer/coach for the first year of SIG funding. The position will do intensive work on-site at local SAAs/TAAs to improve CFT practice. Continued position funding will be evaluated annually based on analysis of progress and needs. Quarterly videoconference meetings will be facilitated by the contracted trainer/coach and NARBHA to cover practice improvement concepts, answer questions, identify success stories, and create a dialogue among facilitators for ongoing support.

   Other proposed training activities for the next year include: developing the shared parenting approach for foster parents, permanency planning skills, treatment approaches for working with substance-abusing families, and substance-exposed newborns, increasing provider skills in working with the zero to five population, and specialized training for working with people with developmental disabilities. NARBHA has allocated prevention funding to train, reimburse, and support family members for their involvement in training and coaching activities.

4. **Improve the effectiveness of barrier identification, resolution, and feedback:** NARBHA will continue to facilitate the monthly Children's System Barrier Resolution Subcommittee as part of the Regional Children's Council. Training materials on the process have been developed and will be posted on the NARBHA website. NARBHA will continue to train providers, stakeholders, and family members on the process. The Subcommittee is an active forum comprised of key stakeholders and family members to identify additional needs for the region, based on identified barriers.

5. **Change to improve the quality management system:** As part of its SIG plan, NARBHA has proposed hiring a full-time Children's Program Integration Analyst. This position will be responsible for design, implementation, monitoring, and managing program measures to bridge quality management with clinical programming and help identify progress specifically related to JK activities.

6. **Internalize the understanding of system reform:** NARBHA will review the JK Annual Action Plan with CEOs and Children's Managers in its provider network who will then be required to review this within their agencies. The Annual Action Plan and NARBHA's commitment will also be reviewed with the Regional Children's Council annually.

7. **Expand available capacity to furnish critical services and supports:** As part of the workforce development plan for ADHS/DBHS, NARBHA will continue to track progress and identify needs in order to reach 100% capacity for serving Title XIX/XXI children through Child and Family Teams by December 2006. NARBHA's sub-contracts with providers will include the provision of this capacity and the training of facilitators in accordance with the established NARBHA standard. NARBHA will also continue to identify specialized needs for the Comprehensive Medical and Dental Program population of children. NARBHA has proposed allocating SIG dollars to curriculum development and coaching, specific to the provision of in-home counseling and family preservation services.

FAMILY INVOLVEMENT

NARBHA is committed to working collaboratively to support family leaders in decision-making and policy development as it pertains to behavioral health at the community, regional, and state levels. NARBHA has created a Family Leadership Committee that meets monthly, includes family members, and is charged with ensuring that families have a voice in all treatment standards/expectations within NARBHA's system. NARBHA staff provides family members with technical assistance and appropriate resources and tools for the work of community and systems development. NARBHA organizes training opportunities to prepare committee members and volunteers to meet the objectives of the committee. NARBHA provides compensation for activities related to family leadership and community development work when, and if, it is not covered as part of an understanding with another organization such as MIKID, NAZCARE, or OCSHCN. Family member training will be tracked by NARBHA staff. This training will serve as the next step in the process of developing a group of family members who ultimately will be available to fill paid and volunteer family support positions for adults and children within NARBHA's GSA.

CO-LOCATION

Co-location with ADES/CPS is currently in place in Fredonia. NARBHA has offered additional co-location positions throughout its GSA to CPS as follows: one position each in Prescott and Flagstaff CPS offices, one position in the Family Advocacy Center in Lake Havasu City, and one position in CPS in either Bullhead City or Kingman. However, many of the CPS offices do not have adequate space to house behavioral health personnel at this time; some rural locations have other collaborative processes in place or are in close physical proximity with behavioral health personnel (less than one mile).

NARBHA is committed to continuing to address co-location needs and collaboration improvement activities with ADES/CPS through the regular DES-Every Other Month (EOM) Meetings. An example: NARBHA/CPS co-facilitated local site visits titled "Improving Inter-Agency Collaboration on Shared Projects", with meetings being facilitated at ten sites region-wide for local CPS and behavioral health staff. These meetings are being run using a Child and Family Team format to review local strengths and challenges to collaborative work on shared projects such as 24-Hour Response and CFT practice.

THERAPEUTIC FOSTER CARE

NARBHA is committed to the ongoing development of the Therapeutic Foster Care network in its GSA, with the intent of keeping children in their own communities and in less restrictive settings. NARBHA intends to do the following: By July 1, 2005, NARBHA will increase child therapeutic foster care beds by five to a total of 43. By December 31, 2005, NARBHA will expand its beds by seven (two in Mohave County, three in Navajo County, and two region-wide) to a total of 50. July 1, 2006, NARBHA will expand its beds to 60 (an additional four in Mohave County, two in Navajo County, and four region-wide). By December 31, 2006, NARBHA will expand its beds to 65 region-wide. This represents a 71% increase over current capacity.

Volume 3, Item r – Limit 1 page.

- **Identify the amount of administrative funding that will be devoted to training per year under this contract. Discuss other funds that will be dedicated to support the training function.**

TRAINING EXPENSE CATEGORIES	(A) NARBHA	(OP) Providers	(OS) SIG*	GRAND TOTAL
Staff Resources				
5.5 FTEs	$17,818	$227,182	$0	$245,000
Estimated Total Expense				$245,000
Administrative Time				
Orientation	$38,547	$211,453	$0	$250,000
In-Service Training				
(e.g. Recovery Model, Barrier Resolution Process, Re-Engagement,				
Family Involvement in Treatment Planning, etc)				
Community & Stakeholder Training				
PDCA Training (training related to Admin Review, ICR & policy updates)				
PIPs & TADs				
ADHS/DBHS Training Requirements				
Collaborative Training (e.g. Brown Bag Lunch Series, NARBHA & DES/RSA				
Annual Conference, etc)				
Estimated Total Expense				$250,000
External Conference and Training				
Workshops (e.g. computer training, business & technical writing, supervisory	$60,000	$120,000	$0	$180,000
& leadership skills, strategic planning, etc)				
Conferences (e.g. NCCBH Annual Conference, Statewide Child Abuse				
Prevention, National Conference Community Antidrug Coalitions of America, etc)				
Conference Sponsorships (e.g. Annual Healthy Families Conference, Annual				
Substance Abuse Summer Institute, National Latina/o Psychological Assoc, etc)				
Estimated Total Expense				$180,000
Training Initiatives				
Essential Learning Computer Based Training (Annual Fee)	$1,800	$25,500	$0	$27,300
Children's System of Care Initiatives (e.g. CFT Facilitator Computer Based	$0	$0	$47,700*	$47,700*
Training, Permanency Planning for Children in Foster Care, Best Practices				
Working with Infants & Toddler in Foster Care, Best Practices for				
Methamphetamine Treatment, Understanding of Meth-using Consumers from a				
Child Welfare Perspective and Substance Exposed Newborns, Improving				
Customer Service & Satisfaction, In-Home & Family Preservation Services, etc)				
Estimated Total Expense				$75,000*
GRAND TOTAL	$118,165	$584,135	$47,700*	$750,000*
Administrative Fund Total (column A)	**$118,165**			
Other Funds Total (column OP + OS)	**$631,835***			
*Pending final approval of Systems Improvement Grant (SIG). This amount may change.				

Volume 4, Item a.1 – Limit 1 page.

- **As discussed at the Site Visit, provide details of the new Quality Management structure and function.**

- **Address the structure/processes Offeror will have in place to assure that provider monitoring results in accountability for quality of care given that there are providers on the Board.**

- NARBHA's Revised Quality Management Structure

  The Leadership Council comprised of the NARBHA CEO, the Department Directors, and other key management staff continues to have responsibility for oversight of all QM activities. The Leadership Council assigns monitoring responsibility to specific internal staff, and in turn Departments, for all provider performance requirements outlined in the ADHS/DBHS Policies and Procedures Manual, the ADHS/DBHS Provider Manual, the AHCCCS Medical Policy Manual, Chapters 900 and 1000, and the ADHS/DBHS and NARBHA QM/UM Plans. Leadership Council receives weekly reports from other committees involved in QM activities, and is specifically responsible for determining any sanctions imposed on the provider network based on failure to meet performance expectations.

  The Leadership Council has designated the Network Monitoring Committee (NMC) as the quality committee for NARBHA. The NMC is responsible for reviewing provider performance information for all Service Area Agencies (SAAs), Tribal Area Agencies (TAAs), and Fee-For-Service providers from a global perspective. The NARBHA Medical Director provides oversight for quality areas. This committee is described in more detail in the Vol.4.a.2 response.

  The Leadership Council has assigned provider liaisons to its SAAs/TAAs, and Fee-For-Service providers to improve communication, assist in reducing or eliminating organizational barriers, and to facilitate individualized improvement plans between NARBHA and the providers for contract performance measures or other complex, high profile processes. The liaisons are not intended to replace regular communication channels and/or monitoring responsibilities as assigned by Leadership Council. The assigned liaisons make up the membership of the Provider Liaison Committee (PLC). This committee is described in more detail in the Vol.4.a.2 response.

  Improvement may occur at any one of the following levels in the organization: 1) staff assigned monitoring responsibility for one or more of the provider performance requirements may initiate, at any time, requests for plans of correction from providers performing below expectation, 2) NMC may request responsible staff members who have not previously initiated plans of correction to develop improvement plans with the involved providers, 3) NMC may request assigned provider liaisons to facilitate meetings between provider staff and the responsible staff at NARBHA to develop improvement plans.

  Quality Management Functions:

  These remain the same as described in the initial response with the exception of removing all references to the Provider Improvement Committee which has been eliminated.

  Personnel and Responsibilities:

  These remain the same as in the initial response with the following exceptions: The job title of the "Performance Improvement Manager", has been changed to the "Provider Monitoring Administrator"; the Grievance and Appeals Administrator has assumed the role of supervising member services; and the UM Data Coordinator position has been filled.

- Process to Ensure Accountability

  The NMC continues to review all provider performance information to ensure that activities that have been undertaken to improve performance do indeed result in improved performance for the specific providers involved. If improvement is not achieved or the plan of improvement is not carried out within acceptable timeframes, the NMC may refer the issue to Leadership Council for implementation of financial sanctions. These financial sanctions continue to be assessed until improvement is achieved. The NARBHA Board of Directors' involvement in the QM/UM process is limited to approving the annual plan. The Board members are not involved in any of the specific improvement activities and therefore have no conflict of interest in this part of the function.

Volume 4, Item a.2 – Limit 1 page.

- **Modify this response to the extent needed to be consistent with the new QM structure and function described in Volume 4, item a.1.**

- **As discussed in the Site Visit, describe consumer involvement in performance improvement activities under the proposed structure.**

- System to Ensure Implementation and Effectiveness of Improvement Activities

  NARBHA has recently revised its committee structure for system-wide Performance Improvement (PI) activities, as follows. The Plan-Do-Check-Act improvement cycle remains the same.

  Leadership Council

  NARBHA Leadership Council remains the oversight body for PI in the provider system. Leadership Council assigns monitoring responsibility to specific internal staff, and in turn departments, for all provider performance requirements. (The responsible staff members can, at any time, request plans of correction from providers if monitoring activity demonstrates substandard performance). Leadership Council reviews and discusses committee reports from the Network Monitoring Committee (NMC), Provider Liaison Committee (PLC), and Plan and Design Committee (PADCO). In addition, Leadership Council approves all recommended provider financial sanctions resulting from sub-standard performance.

  Network Monitoring Committee (NMC) (formerly called the Provider Performance Committee)

  NMC is responsible for reviewing performance information gathered by responsible staff members on all Service Area Agencies, Tribal Area Agencies, and Fee-For-Service providers. This information includes quantifiable performance indicator data, and less quantifiable information monitored and reported by all NARBHA Departments. NMC identifies areas for improvement from a global perspective, taking into account whether plans of correction have already been initiated by responsible staff members. If processes requiring improvement need modification to achieve the desired level of performance, NMC refers them either to responsible staff or to the assigned provider liaison to develop improvement plans. The liaisons are typically identified as responsible for facilitating the development of improvement plans when high profile and/or complex processes are involved. If processes require major design or redesign efforts to reach performance expectations, NMC forwards the issues to PADCO. NMC reviews a status update report on the current improvement plans and requested plans of correction at each meeting and assists the department representatives or the assigned liaisons in working through any barriers.

  Provider Liaison Committee (PLC) (formerly called Performance Improvement Committee)

  The PLC acts as a working committee comprised of all the assigned provider liaisons. It is responsible for reviewing the status of improvement plans, discussing any barriers that have arisen, identifying provider systems issues, and suggesting best practices for use in other agencies. The committee meeting is used extensively for training the liaisons on all applicable policies, procedures, and performance requirements to ensure consistency between liaisons. The provider liaisons meet with their providers on a quarterly basis to go over the performance data reviewed by NMC. When NMC forwards the need to develop an improvement plan to a liaison, the liaison facilitates a meeting between staff at the provider site involved in the process and the NARBHA staff assigned responsibility for monitoring the process. In addition, consumers and/or family members participate in improvement plan development meetings when the monitoring data depicting a problem is a result of consumer and/or family member feedback.

- **Consumer Involvement**

  Consumers have the opportunity to provide input to the PI system through consumer satisfaction surveys, complaints/grievances, the NARBHA Family Leadership Committee, community forums, consumer representatives on NARBHA Board of Directors and the Children's System Barrier Identification process. When consumer feedback identifies an improvement opportunity, consumers and/or family members are invited to participate in sessions with NARBHA and the relevant providers to create individualized improvement plans. Consumers and/or family members who are interested in participating on teams to improve processes will be prospectively identified from each provider agency area so that they can be readily available to participate when needed.

Volume 4, Item a.3 – Limit 1 page.

- **Describe how behavioral health recipients and families are notified of any open meetings, including but not limited to planning meetings and Board Meetings.**

NARBHA notifies members, family members, and stakeholders of public meetings through a variety of mechanisms.

- For select meetings held for the purpose of stakeholder and community input in the development of planning documents and as part of needs assessment processes a wide range of interested individuals, including recipients and family members, are invited through mailings, announcements at stakeholder meetings and through the NARBHA Family Leadership Committee described below.

- The NARBHA Family Leadership Committee, consisting of family members of recipients and representatives of various behavioral health advocacy groups such as NAMI, MIKID, NAZCARE, OCSHCN, Parenting Arizona, and Arizona's Children's Association, provides notification concerning NARBHA's public meetings on its website and through its newsletter to recipients and family members in the Northern Arizona Geographic Service Area.

- NARBHA has a number of email lists, such as the Family Driven Coalitions, and other specific groups, which it uses to provide a variety of information including notifications of specific meetings related to those groups including public meetings.

- NARBHA posts notification of open public meetings, including the monthly Board of Director meetings, on the NARBHA website. Additionally, monthly Board meeting notification is posted in the NARBHA lobby.

Volume 4, Item a.8 – Limit 1 page.

- **Provide assurance that monitoring will incorporate the requirements of the AHCCCS Medical Policy Manual Chapter 900, Section 920 and ADHS/DBHS QM/UM Plan.**

Identifying the Focus of Monitoring Activities

On an annual basis, the NARBHA Leadership Council (comprised of the NARBHA CEO, Department Directors, and other key management staff) identifies the focus of monitoring activity to be conducted by NARBHA staff. The focus will be derived from all provider performance requirements outlined in the ADHS/DBHS Policies and Procedures Manual, the ADHS/DBHS Provider Manual, the AHCCCS Medical Policy Manual, Chapters 900 and 1000, and the ADHS/DBHS and NARBHA QM/UM Plans. Specifically NARBHA hereby provides assurance that monitoring will incorporate the requirements of the AHCCCS Medical Policy Manual Chapter 900, Section 920, and ADHS/DBHS QM/UM Plan. Leadership Council will assign monitoring responsibility to specific internal staff, and in turn Departments, for each of the performance requirements listed in the above source documents.

Volume 4, Item a.9 – Limit 1 page.

- **Discuss monitoring of the delegated prior authorization function to SAA's, inclusive of prospective and retrospective monitoring.**

NARBHA has delegated the function of Prior Authorization of Level I inpatient and Level II residential services to its nine Service Area Agencies and Tribal Area Agencies (SAAs/TAAs) in GSA 1. This process ensures that the clinical treatment team at the provider level who is most familiar with the member and family is the decision making body for initial and continued authorization of these high level, intensive services, while also ensuring that ADHS/DBHS and NARBHA standardized criteria is utilized to make decisions throughout the network.

NARBHA communicates initial and continued authorization criteria and expectations to the SAAs/TAAs through policy and contract. Any initial denials of prior authorized Level I or Level II services by the SAAs/TAAs are forwarded to NARBHA within 24 hours. Compliance with NARBHA standards is monitored retrospectively on a quarterly basis through clinical record review at the SAA/TAA sites to determine the appropriateness of the clinical decision for admission and continued stay decisions. Data is aggregated for each provider agency as part of the Utilization Management Record Review process, and reviewed by NARBHA each quarter to determine compliance with standards. There have been no patterns of provider non-compliance with NARBHA expectations for prior authorized services.

Consequently, implementation of a prospective prior authorization monitoring structure will be based upon a targeted sample and review, in addition to retrospective monitoring currently in place. For the first week of each quarter, NARBHA will require each SAA/TAA to submit documentation to NARBHA for adult and child admissions to Level I and Level II services. The documentation will be reviewed by NARBHA to ensure compliance with standards and criteria, and improvements will be initiated with providers if non-compliance is identified.

Volume 4, Item b.1 – Limit 1 page.

- **Regardless of details in the proposal, provide an attestation that Offeror will comply with all DHS Grievance and Appeals requirements.**

Regardless of details in the proposal, NARBHA hereby attests that it will comply with all ADHS/DBHS Grievance and Appeals requirements as they will exist on July 1, 2005 or as they may be modified by ADHS/DBHS in the future.

Volume 4, Item b.3 – Limit 1 page.

- **Regardless of details in the proposal, provide an attestation that Offeror will comply with all DHS Grievance and Appeals requirements.**

Regardless of details in the proposal, NARBHA hereby attests that it will comply with all ADHS/DBHS Grievance and Appeals requirements as they will exist on July 1, 2005 or as they may be modified by ADHS/DBHS in the future.

Volume 4, Item b.4 – Limit 1 page.

- **Discuss how Designated Representatives will be utilized to ensure consumers understand grievance and appeals rights. (Reference A.A.C.R-9-21-101)**

- **Regardless of details in the proposal, provide an attestation that Offeror will comply with all DHS Grievance and Appeals requirements.**

- Consumers receiving services within the NARBHA provider network, or their guardians, have the right to designate a person to assist the consumer in protecting the consumer's rights and voicing the consumer's service needs. Consumers are informed of this right in accordance with state regulations in A.A.C. R9-21.

  If a consumer designates a representative to assist in filing grievances or appeals, NARBHA and its providers give all required notices to the designated representative and, if the designated representative is not a trained person such as an attorney or advocate from the Office of Human Rights, NARBHA actively works to educate the designated representative about the grievance and appeals processes. Besides the provider employees who assist consumers and their designated representatives in filing grievances and appeals, NARBHA's Grievance and Appeals Administrator and its member representatives are involved in educating and informing personal representatives of the procedures, timelines, etc. so they can provide informed assistance to the consumers.

- Regardless of details in the proposal, NARBHA hereby attests that it will comply with all ADHS/DBHS Grievance and Appeals requirements as they will exist on July 1, 2005 or as they may be modified by ADHS/DBHS in the future.

Volume 5, Item a – Limit 5 pages.

- **Offeror states that 5 out of 7 servers will be replaced. Provide contingency plan for replacement.**

As stated in the original response to the RFP, NARBHA had planned to replace five servers this fiscal year. At this time NARBHA is planning to defer replacing one of these servers, SERVER "CMHCHOST", until early in FY05-06 for various business reasons.

- NARBHA's software vendor, CMHC, is in the process of certifying their software package, the CMHC Management Information Systems (CMHC/MIS) application, for use on the next generation of the Santa Cruz Operation (SCO) UNIX operating system(s). Without that certification NARBHA would have no support for the CMHC/MIS.
- CMHC is finalizing the hardware/software specifications for integration of its proprietary database(s) with the open architecture Microsoft/SQL databases. Purchasing/implementing a new server prior to these being finalized could prove costly later if modifications/upgrades are necessary.

The remaining four servers identified in the original RFP response will be replaced this fiscal year.

For each new server, the new hardware and software will be installed concurrently, enabling NARBHA to perform an "across-the-wire migration". This process keeps the existing server fully undisturbed while the new server is being configured. Data from the old server are then copied to the new server. The old server is powered off and the new server is brought up to take its place. In the unlikely event that data on an old server are accidentally harmed in this process, a 'bare metal restore' will be employed to bring the old server back to its pre-upgrade condition. A 'bare metal restore' requires no manual reinstallation of operating systems or software. Only preconfigured bootable media and the latest full backup are required to safely and quickly restore the server to its original state. All bootable media are tested for integrity at the time of creation to ensure their reliability.

The four replacement servers will be deployed one at a time, with no interruption to NARBHA's business operations. When replacing existing data services, cutovers to all new servers are performed outside of normal business hours, specifically on weekends. This affords the opportunity to efficiently handle any technical difficulties that are encountered and provides ample time for thorough testing of data services components.

Planning assumptions are:

- All hardware/software will be received at NARBHA within three weeks of placing the order.
- Each server will take two weeks to configure, test, and implement (replace old server), taking eight weeks total.

Assuming order placement on or before April 8, 2005, NARBHA will have the four servers replaced by July 1, 2005.

Volume 5, Item c – Limit 3 pages

- **Describe in detail the paper claims submission process, including the retention of paper claims.**

Health Care Claims/Institutional and Professional (HIPAA 837I/P)

All Service Area Agency (SAA) providers and some Fee for Service (FFS) providers submit claim transactions to NARBHA electronically.

- In FY03-04 this comprised 90.6 % of the total claims submitted.
- In the first half of FY04-05 this comprised 95.6 % of the total submitted.
- The remainder of the Fee for Service (FFS) providers, all Single Case Agreement (SCA) providers, and both Tribal Area Agency (TAA) providers submit paper claims.
- In FY03-04 this comprised 9.4 % of the total submitted.
- In the first half of FY04-05 this comprised of 4.4 % of the total submitted.
- Paper claims are submitted manually in hard copy via U.S. mail or in-person delivery. Instructions for submitting paper claims are found in the ADHS/DBHS/NARBHA Provider Manual Section 6.1/*Submitting Claims and Encounters* and posted on www.narbha.org under the heading "ADHS/NARBHA Provider Manual".
- Receipt and handling of these hard-copy/paper claims are as follows.
- All paper claims are opened and date-stamped by the Administrative Services Office Specialist.
- Claims are then delivered by the Administrative Services Office Specialist to Claims staff (usually the Claims Processor, but in her absence to the Claims Coordinator). If neither the Claims Processor nor the Claims Coordinator is available, the Office Specialist places the claims in a locked drawer in the office of the Office Specialist until they can be delivered in person. At no time are claims placed by the Administrative Services Office Specialist in Claims staff mailboxes.
- Claims are then separated and sorted by the Claims Processor or the Claims Coordinator by claim type (HIPAA 837/Professional and HIPAA 837/Institutional) and date received order, and placed in a locked closet in the Claims Processor's office.
- Claims are assigned by the Claims Coordinator to the Claims Processor for entry into the NARBHA data entry database (reference '*NARBHA holding database'* in original data flows), a process that usually takes less than one week and no more than four weeks.
- During data entry, when claims are on the Claims Processor's desk, the office is locked when not occupied.
- After the claims adjudication process has been completed, claims are attached to the Explanation of Benefits (EOB) and placed in provider order in a locked filing cabinet, which is in the locked closet in the Claims Processor's office, which in turn is locked when not occupied.
  - Claim adjudication runs are processed on a pre-established schedule based on claim type (HIPAA 837/Professional vs. HIPAA 837/Institutional)
  - The paper claims remain in the office of the Claims Processor until the end of the fiscal year that is two years after the current fiscal year. Then they are moved to a secure off-site storage site where they are kept until they are ten years old, per current NARBHA policy.

Volume 5, Item e – Limit 1 page.

- **Provide assurances that the T1 line will be installed by July 1, 2005.**

When the award of the contract for GSA 1 has been finalized NARBHA will:

- Place the order for the T1 installation and provisioning. Typically this process takes no more than 45 days and could be less because the major installation effort will be in the Phoenix metropolitan area
- If there are equipment needs for the termination points (NARBHA and ADHS) order(s) will be placed for the equipment at the termination points (NARBHA and ADHS).
- Assuming an installation date within the estimated 45 days stated above, NARBHA will begin testing with ADHS/DBHS data line connectivity. The assumption is that testing will take no more than 30 days to complete.

Assuming that T1 line installation and provisioning takes no more than 45 days and that the testing with ADHS/DBHS takes no more 30 days, the T1 between NARBHA and ADHS/DBHS can be implemented by 7/01/2005 if the initial order is placed no later than April 15, 2005.

Assuming order placement on/before April 15, 2005 NARBHA will have the T1 to ADHS/DBHS installed, tested, and accepted on/before 7/01/2005.

Volume 5, Item k – Limit 10 pages.

- **Describe how and when edits are applied.**

The various edits used in the NARBHA data systems are based on the various edits and requirements defined by Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) as well as the national standards embodied in the Health Insurance Portability and Accountability Act (HIPAA) concerning data file creation/submission and content. In addition, NARBHA has defined several edits that apply to information it receives.

These various edits are applied as follows:

Benefit Enrollment and Maintenance Transaction (HIPAA 834)

These edits are applied to these data at three distinct times in the data entry/submission processes.

- At the time of data entry, all information entered is valid based on requirements set forth by HIPAA, ADHS/DBHS, and NARBHA.
  - Data entry transactions/screen control the data element length, content, and type.
  - Information that does not meet these requirements cannot be entered into the remote system(s).
- At the time information is extracted from the remote system(s), it is passed through a version of the Collection and Scanning Program/Edit Reporting (CASPER834) program used by the Service Area Agency/Tribal Area Agency (SAA/TAA) at its site to scan for proper field content, accuracy of data, reasonableness of data, correct length of the data fields, correct values, and non-allowable characters. Examples are:
  - Valid gender identification
  - Valid marital status
  - Name construction per HIPAA standards (first, last, prefix)
  - Date of birth
- Once the data have been passed to NARBHA they are again run through the CASPER834 program at the NARBHA site, identical to the version used at the SAA/TAA. All edits are reapplied to ensure that the information is correct. Additional edits scan enrollment information for duplicate submission from multiple SAAs/TAAs.
- **All data** submitted that are specific to a given member/transaction must pass **all edits** defined above prior to being applied to the NARBHA MCO databases.

The CASPER834 program is maintained at NARBHA and embodies these various edits. NARBHA maintains a master document detailing data field requirements, edit criteria, and cross-validation considerations that support the CASPER834 process. The CASPER834 and Companion data field Requirements (ver 5.00.00) document is available for review. The more complex edits are defined below as *Attachment 5.k.r.1 - CASPER834 Edit Rules*.

The strength of these edits is that they are applied in three separate/discrete steps (data entry, CASPER834 twice), at two different levels (SAA/TAA and NARBHA), and are reviewed by staff at each level.

Client Information System (CIS) Demographic

These edits are applied to these data at three distinct times in the data entry/submission processes.

- At the time of data entry, all information entered is valid based on the requirements set forth by HIPAA, ADHS/DBHS, and NARBHA.
  - Data entry transactions/screen control the data element length, content, and type.
  - Information that does not meet these requirements cannot be entered into the remote system(s).
- At the time information is extracted from the remote system(s), it is passed through a version of the Collection and Scanning Program/Edit Reporting (CASPERCompanion) program used by the SAA/TAA at its site to scan for proper field content, accuracy of data, reasonableness of data, correct length of the data fields, correct values, and non-allowable characters. Validation checks across multiple data elements are also performed at this time. Examples are:
  - Alpha characters in the SSN
  - Males that are identified as part of special populations indicating pregnancy (gender vs. special pop.)
  - Members over 18 years of age that are identified as children (program vs. date of birth)
- Once the data have been passed to NARBHA, they are again run through the CASPERCompanion program at the NARBHA site, identical to the version used at the SAA/TAA. All edits are reapplied to ensure that the information is correct.
- **All data** submitted that are specific to a given member/transaction must pass **all edits** defined above prior to being applied to the NARBHA MCO databases.

The CASPERCompanion program is maintained at NARBHA and embodies these various edits. NARBHA maintains a master document detailing data field requirements, edit criteria, and cross-validation considerations that support the CASPERCompanion process. The CASPER834 and Companion Data Field Requirements (ver 5.00.00) document is available for review. The more complex edits are defined below as *Attachment 5.k.r.2 - CASPERCompanion Edit Rules*.

The strength of these edits is that they are applied in three separate/discrete steps (data entry, CASPERCompanion twice), at two different levels (SAA/TAA and NARBHA), and are reviewed by staff at each level.

Health Care Claim Institutional/Professional (HIPAA 837/P and HIPAA 837/I)

These edits are applied to these data at NARBHA using three distinct processes.

- At the time **any provider** creates an electronic HIPAA 837I/837P claim transaction, many validations/edits are applied by their software program that enforce specific HIPAA-mandated validation rules on the claims.
- When NARBHA receives the information, it is loaded into the holding database for adjudication. This load process converts the HIPAA 837I/837P data into a data set that supports the claims adjudication process. This conversion process, using the standards set by HIPAA for data content, length, and type, enforces specific validation rules on the claims data.
- During this load process, specific *CMHC Claim Edits* are applied to the claims that are specific to the CMHC implementation of claims adjudication.
- After the completion of the load process, NARBHA applies the *NARBHA Internal Edits* specific to the NARBHA system. These edits are based on requirements set by ADHS/DBHS as well as NARBHA internal needs.
- After application of the *NARBHA Internal Edits*, NARBHA applies several in-house processes, developed using USCRIPT, that further edit the claims for uses of claim service code modifiers and place of service identifiers.
- At the time that **all data** have been subjected to **all edits** defined above, the data are presented on stratification reports for further manual review and/or correction.

The NARBHA Claims Edits document is available for review. The more complex edits are defined below as *Attachment 5.k.r.3 - NARBHA Claims Edit Rules*.

Attachment 5.k.r.1 - CASPER834 Edit Rules.

All edits begin at data entry time with data entry forms designed to minimize or disallow invalid entry. This is accomplished through the use of data tables that only allow valid entry, ranges, file types, and/or defaults. CASPER834 allows for a more thorough validation process by comparing all submitted data to additional data sources, such as the State Roster Data provided to RBHAs.

Edits are defined in the Client Information System (CIS) File Layout and Specification Manual (ver1.19 revision date 8/02/2004) through ADHS/DBHS policy definition/clarification and/or meetings with DBHS/ADHS staff. NARBHA mirrors all ADHS/DBHS edits to ensure data are submitted accurately, and incorporates the requirements into the data entry processes at each data entry site and the CASPER834 process. Examples of the more complex edits and those edits that cross-validate the information are defined below.

- 834 Admit Date is compared to all previous enrollments at ADHS/DBHS.
  - The submitted admit date must be after any previous discharge date, either at NARBHA or statewide.
  - Any prior enrollment for the member must be closed to eliminate enrollment segment overlapping.
- Using the NARBHA Internal ID, CIS ID, AHCCCS ID, and/or SSN, CASPER834 checks the ADHS Statewide Enrollment Roster File to see if the member has been enrolled previously.
  - If there is any match using any of these keys, then the last name, first name, DOB, gender, SSN, and AHCCCS ID of the current enrollment and the ADHS Statewide Enrollment Roster File enrollment data must be identical.
  - If they are not identical, the enrollment is rejected.
- Any/all data elements defined in the HIPAA 834 Benefits Enrollment Maintenance transactions as required must be present.
- Any/all values for the data elements defined in the HIPAA 834 Benefits Enrollment Maintenance transactions must conform to HIPAA codes set definitions.
- The HIPAA 834 Benefits Enrollment Maintenance transactions discharge date must be on or after the last paid claim of medication service recorded in the NARBHA data system(s).
- The HIPAA 834 Benefits Enrollment Maintenance transactions discharge date must be on or after the corresponding Admit Date.

Attachment 5.k.r.2 - CASPERCompanion Edit Rules.

As is the case for the HIPAA 834 process, edits begin at data entry time with data entry forms designed to minimize or disallow invalid entry. This is accomplished through the use of data tables that only allow valid entry, ranges, file types and/or defaults. CASPERCompanion allows for a more thorough validation process by comparing all submitted data to additional data sources, such as the State Roster Data provided to RBHAs.

Edits are defined in the Client Information System (CIS) File Layout and Specification Manual (ver1.19 revision date 8/02/2004) through ADHS/DBHS policy definition/clarification and/or meetings with DBHS/ADHS staff. NARBHA mirrors all ADHS/DBHS edits to ensure data are submitted accurately, and incorporates the requirements into the data entry processes at each data entry site and the CASPERCompanion process. Examples of the more complex edits and those edits that cross-validate the information are defined below.

- Demographic Client population must agree with the DOB accepted with the HIPAA 834.
  - A child may not be over 18 years of age; an adult may not be under 18 years of age.
- Demographic OMB codes must agree with the HIPAA 834 race value.
- Demographic Diagnosis data must support the client population.
  - A population/program identifying a member as Seriously Mentally Ill (SMI) must have a qualifying diagnosis per DBHS policy.
  - A child with a serious emotional disturbance (SED) must have a qualifying diagnosis per DBHS policy.
- Diagnoses are verified against DBHS provided table/databases for ICD9 values.
  - Diagnoses present and identified as AXIS I must be valid AXIS I diagnosis.
  - Diagnoses present and identified as AXIS II must be valid AXIS II diagnosis.
- Health Plan identifier must be present if the member has been identified as having Title XIX/XXI eligibility.
- Demographic special populations must agree with 834 gender value.

Attachment 5.k.r.3 - Claim Edit Rules.

These edits are applied during the claim adjudication process described above. Edits pertaining to date length, type, content and adjudication rules are defined in the Client Information System (CIS) File Layout and Specification Manual (ver1.19 revision date 8/02/2004) through ADHS/DBHS policy definition/clarification and/or through meetings with DBHS/ADHS staff. There are many more edits then those defined below, but these are the more complex/critical edits.

Error Name	Description	Applies to HCFA/UB	Error Code	Comments
CMHC_01	Client id not found - not enrolled	H, U	01	Not enrolled
CMHC_02	Service date not in enrollment	H, U	02	DOS is outside enrollment segment
CMHC_04	Service category/fund source/ type of service not in contract.	H, U	04	
CMHC_05	Authorization required and not found.	H, U	05	
CMHC_06	Authorization required and service over limit	H, U	06	
CMHC_07	Billed units and duration conflict	H, U	07	
CMHC_08	Duplicate service	H, U	08	Defined by Member, provider, DOS, service code, modifier 1, modifier 2, place of service
CLAIMA6	Member age < 18 and diagnosis code = V71.01'	H	19	
CLAIMA7	Member age < 18 and service code = 90899 or diagnosis = V71.01	H	19	
CLAIMC2	Service date can not be older than 6 months	H,U	1	These are reviewed and approved through Finance Dept.
CLAIMD1	Claim diagnosis is invalid. Checks against internal diagnosis table data code table 148.	H,U	3	
CLAIMD3	Occurrence code 1 equals 42 and the occurrence date 1 is valid	U	32	

Error Name	Description	Applies to HCFA/UB	Error Code	Comments
	Or occurrence code 2 equals 42 and the occurrence date 2 is valid or occurrence date is present and no occurrence code is present or occurrence code is present and no occurrence date is present			
CLAIMD10	Diagnosis code = 7999 and service code not equal to S0001 – S9999, A0001-A9999, Z0001-Z9999	H,U	1	J10 denial code
CLAIMH1	S8000,S8001,S8002,S8003,S8004 service codes can only be billed under client id HI010115F0	H,U	21	
CLAIMI1	Claim client id matches against a client id in the MCO system	H,U	18	
CLAIMJ1	Diagnosis = 799.9 and Service code NOT equal to >S000'->S9999' or >A000'->A999' or >Z000'->Z999'	H,U	3	
CLAIMM2	Medicare status equals >Y= and TPL source code not equal to MB and service date greater than 01/31/2000.	H	46	
CLAIMM3	Medicare status equals >Y= and Medicare payment is greater than zero and Medicare allowed and deductible are empty.	H	47	
CLAIMM4	Medicare status equals >Y= and Medicare deductible amount is empty	H	48	
CLAIMM5	Medicare status equals >Y= and Medicare payment amount is empty	H	49	
CLAIMM6	Medicare status equals >Y= and Medicare allowed amount, deductible and payment amount is 0.00 and the denial code is empty	H	34	
CLAIMM7	Medicare status equals >Y= and Medicare allowed amount, deductible and payment amount is 0.00 and the denial code is not a valid denial. Checks against data code table 919.	H	35	

Error Name	Description	Applies to HCFA/UB	Error Code	Comments
CLAIMMD2	Modifiers/Place of service is not an allowable combination.	H	39	
CLAIMM8	Medicare status equals >N= and Medicare allowed amount is 0.00	H	35	
CLAIMPS	Place of service errors	H	14	
CLAIMT1	Claim TPL source code range equal to MC, MB, CI	H,U	6	
CLAIMT3	TPL source code range equals MB, CI and TPL carrier name is empty	H,U	8	

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- **Resubmit the response to this item using the following revised amount based on annualized November 2004 data.**
  - **GSA 1: $6,316,602**

The audited NARBHA Financial Statements provided in response to question 6.c show NARBHA Net Assets at June 30, 2004 of $10,230,024 which exceed the 90% capitalization requirements for GSA 1, as stated in the Best and Final Offer letter dated January 28, 2005, of $6,316,602. NARBHA anticipates no material decreases in the level of Net Assets prior to the contract date of July 1, 2005.

Given the difference between current Net Assets and the amount represented currently by the 90% capitalization requirement, NARBHA's existing financial position allows for significant growth while remaining in compliance with this requirement. In addition, NARBHA's CEO, CFO, and management staff, along with NARBHA's Board of Directors, are familiar with the 90% capitalization requirement and are committed to sustaining compliance through maintaining a strong balance sheet.